General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** J & J G Dickson & Son Ltd, 154 Main Street, Cambuslang, Glasgow, South Lanarkshire, G72 7EL

**Pharmacy reference:** 9011752

**Type of pharmacy:** Community

**Date of inspection:** 22/10/2024

## Pharmacy context

This is a community pharmacy situated on the main high street through Cambuslang, in Lanarkshire. A GP surgery is located nearby, and another pharmacy which belongs to the same company is located on the same road. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including the pharmacy first scheme. It acts as a small hub pharmacy, dispensing  medicines in multi-compartment compliance packs for some of the company's other branches.

## 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 team has written procedures to help them to provide services safely and effectively. The pharmacy keeps the required records. And team members know how to keep people's private information safe. They discuss when things go wrong, but they do not record details about their reviews. So they may not always be able to show what learning they identify and how they are improving the quality of their work.

### Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). Members of the team had signed to say they had read and understood the SOPs. Risk assessments had been completed for some of the services provided, such as use of the automated compliance pack dispensing machine. But two of the risk assessments conflicted with each other about how long the medicines could be used once they had been de-blistered from their original packaging. One stated the pharmacy should hold more than 14 days of de-blistered medicines, whilst the other stated that the de-blistered medicines must be used within 14 days of being de-blistered. So it was not clear whether the pharmacy had addressed this risk in full. The superintendent pharmacist subsequently acknowledged historic assessments had been provided, and they would review current practice to ensure the correct procedures were being followed.

The pharmacy kept electronic computer records of dispensing errors. This included any learning outcomes. There was a separate computer record to log near miss incidents. The pharmacist discussed any incidents with members of the team at the time they occurred to help identify potential learning points. For example, the team had held a discussion about the dispensary workflow to reduce distractions. The pharmacist reviewed the records each month but did not record when this had taken place and didn't perform an analysis to look for underlying trends. So the pharmacy may not to be able to show they are doing all they can to learn from their mistakes.

The roles and responsibilities for members of the team were recorded on a table at the front of the SOP folder. A new member of the team explained what their responsibilities were and was clear about the tasks that could or could not be conducted in the absence of a responsible pharmacist. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure, but information about it was not on display to the public. Which would help to encourage people to provide feedback. Any complaints were recorded and followed up by the pharmacist manager. A current certificate of professional indemnity insurance was seen.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were suitably kept. Running balances were recorded and checked frequently. A separate register was available to record patient returned CDs.

Information governance procedures had been implemented and members of the team had completed data protection training. When questioned, a dispenser described how confidential information was separated and destroyed using a shredder. A privacy notice was on display which described how the pharmacy handled and stored people's private information. Safeguarding procedures were available and the contact details for the local safeguarding team were on display. Members of the team explained they would refer any concerns to the pharmacist in the first instance.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough suitably skilled team members to manage the workload safely. And they feel comfortable providing feedback and raising any concerns they have to help improve services. They complete some ongoing learning. But this is not structured, so their learning needs may not always be fully identified and addressed.

### Inspector's evidence

The pharmacy team included a pharmacist manager, three dispensers, one of whom was in training, and a new member of the team. A separate team operated the hub and consisted of three dispensers, one of whom was trained to complete accuracy checks of medicines. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be well managed. Staffing levels were maintained by a staggered holiday system and relief staff.

Members of the pharmacy team had completed some additional training. For example, they had recently undertaken training provided by a medicine manufacturer about tranexamic acid. A training folder for each member of the team contained records of completed training to show what they had completed. But ongoing training was not provided in a consistent manner, which would help to ensure learning needs were met. A dispenser provided examples of selling a pharmacy only medicine using the WWHAM questioning technique, refusing sales which they felt were not appropriate, and referring people to the pharmacist when needed. Team members provided examples of how they would provide the pharmacy first service, including when they were able to carry out the consultation, or refer the person to the pharmacist.

Members of the team were seen working well together and assisted each other with any queries they had. Newer team members felt a good level of support and felt able to ask for further help if they needed it. They discussed their work each day and shared any learning points. The pharmacy manager was instated five months ago and had not yet completed appraisals. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to their line manager. The pharmacist manager was able to exercise their own professional judgement and was not under pressure to achieve targets set for some professional services.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available for people to have a private conversation with a member of the team.

### Inspector's evidence

The premises were clean and tidy, and appeared to be adequately maintained. Access to the dispensary was restricted. The temperature was controlled using air conditioning units and lighting was sufficient. Team members had access to a kitchenette area and toilet facilities.

A consultation room was available. It was tidy with a computer, desk, seating, wash basin, and adequate lighting. The patient entrance to the consultation room was clearly signposted.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from licensed sources, mostly stores them appropriately and carries out regular checks to help make sure that they are in good condition. But it keeps some medicines outside of the manufacturer's containers and it doesn't have clear guidance for team members of how long they can store these medicines like this.

### Inspector's evidence

The pharmacy and consultation room were easily accessible by those with additional mobility needs. Information was on display about the services offered. The pharmacy opening hours were also on display. The pharmacy had a medicines delivery service, and electronic delivery records were kept. Unsuccessful deliveries were returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Members of the team initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to provide an audit trail for medicines dispensed in the pharmacy. They used baskets to separate individual patients' prescriptions to avoid items being mixed up. Dispensed medicines awaiting collection were put inside medicine bags and kept inside alphanumerical storage boxes on collection shelves. Stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Members of the team were seen confirming the patient's name and address when medicines were handed out.

If a prescription indicated it was to be dispensed in instalments at a set interval, a paper record was attached to the prescription. Members of the team checked compliance and whether they had any questions about their medicines. Any notes from the counselling advice provided were recorded, alongside the date of supply. If team members were concerned about a person's compliance with their medicines, they would refer them to the pharmacist before speaking to their GP surgery.

The pharmacy did not routinely highlight medicine bags when they contained schedule 3 or 4 CDs. So team members may forget to check the prescription expiry date. The pharmacist used reminder stickers if they identified a need to provide counselling. For example, to people who were commenced on higher-risk medicines (such as warfarin, lithium, and methotrexate). But the team did not routinely counsel people who had been taking these medicines for some time. This was a missed opportunity to ensure people continued to take their medicines safely and were up to date with blood tests. Members of the team were aware of the risks associated with the use of valproate-containing medicines, and the need to supply original manufacturer's packs. Educational material and counselling advice was provided with the medicines. The team also was aware of the counselling advice which needed to be provided with topiramate. But details of counselling advice were not always recorded. Which would help to improve a person's continuity of care.

An unscheduled care scheme enabled people to access medicines from the pharmacy if they been previously prescribed by their usual prescriber and at the pharmacist's discretion. The pharmacist had signed the relevant PGD in order to make the supply. An example utilising the scheme was for people who had been prescribed amoxicillin 500mg capsules, but due to a wholesale supply issue these capsules were not available to dispense. The pharmacist dispensed amoxicillin 250mg capsules and counselled them about how to take double of the lower strength.

The pharmacy first scheme was provided by the pharmacy. Members of the pharmacy team showed a good understanding of the service and the formulary of medicines which could be supplied. They provided examples of when they had made a supply on the scheme, and also when they had referred people elsewhere. If the request was for a prescription only medicine permitted by the scheme, they would refer the person to the pharmacist for a consultation under the relevant PGD. The pharmacist said if they could not help someone and they felt the person needed urgent care, they would contact the GP surgery and request a same day appointment if any were available.

Some medicines were dispensed into multi-compartment compliance packs for other branches in the same company using an automated dispensing system. The clinical checks of prescriptions were completed by the pharmacist in the relevant branch. And details of the prescription were uploaded directly to the computer software. Team members prepared the compliance packs for each pharmacy branch. This involved sorting the required number of compliance packs with the correct labels, and dispensing any medicines which could not be dispensed by the automated system. This was done by manually adding medicines to the trays by hand, using barcode technology. When the barcode on the compliance pack was scanned by the dispenser, a screen showed which tablet needed to be put into which slot in the compliance pack. The packs were then loaded into the automated dispensing system, for the rest of the medication for that person to be dispensed. The pharmacy had a two-stage accuracy checking process. The first was a quantity check by a dispenser, who checked each slot to ensure the correct number of tablets had been dispensed and that they had not been accidentally broken. There was then a final accuracy check of the medicines by a trained accuracy checker. Team members explained there were very few errors made and the near miss records reflected this. A set of SOPs were available for the process, and each had been signed by members of the team.

The automated dispensing system required a continuous input of medicines which had been de-blistered out of their original packs. The pharmacy used a de-blistering machine to achieve this, and storage tubs for individual medicines. Only medicines with the same batch number and expiry date were stored inside storage tubs, and these details were kept, including who had de-blistered the medicines and when. But the pharmacy team were not aware how long medicines should remain in the storage tubs for. And they were not aware about the length of time which had been stipulated within the company's risk assessment to control this. So there is a risk the length of time some medicines have been de-blistered for may be overlooked.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. A date checking record was available. The expiry dates of medicines were checked once every three months. Short-dated stock was highlighted using a sticker. Liquid medications had the dates of opening written onto the bottle. Controlled drugs were stored in the CD cabinets, with clear separation between current stock, patient returns and out of date stock. There was a clean medicines fridge, equipped with a thermometer. The minimum and maximum temperatures were recorded using electronic software and had been in range for the past month. Patient returned medication was disposed of in designated bins. Medicine recalls and patient safety alerts were received by email. A record of the action taken and when was kept showing how the pharmacy had responded to the alert.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they keep the equipment clean in a manner expected of a healthcare setting.

### Inspector's evidence

Team members accessed the internet for general information. This included access to the British National Formulary (BNF), BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were used for methadone to prevent cross contamination. The pharmacy also had counting triangles for counting loose tablets, including a designated counting triangle for cytotoxic medicines. Equipment was kept clean.

The automated compliance pack dispensing system was routinely serviced by the manufacturer at least once every three months. Maintenance records were kept. Team members also cleaned and dusted the system throughout the week. But they did not keep records of this activity, which would be useful in the event of a query or concern.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless telephone was available in the pharmacy which allowed team members to move to a private area if the telephone call warranted privacy. The consultation room was used appropriately. People were offered its use when requesting advice or when counselling was required.

## 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. |