General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Abbotswell Pharmacy, 2 Abbotswell Crescent, Kincorth, ABERDEEN, Aberdeenshire, AB12 5AR

Pharmacy reference: 1041591

Type of pharmacy: Community

Date of inspection: 21/09/2020

Pharmacy context

This is a community pharmacy beside other shops in a residential area of the city. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and delivery service for multi-compartment compliance packs. It also provides substance misuse services, a smoking cessation service and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use and supplies a range of over-the-counter medicines. The pharmacist owner works full-time in the pharmacy. This pharmacy was visited during the COVID-19 pandemic.

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 members follow written processes for the pharmacy's services to ensure they provide them safely. The pharmacy has made suitable changes to its procedures to help reduce the risks to people during the pandemic. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people. They record some mistakes to learn from them, but don't review these regularly to identify common themes. So, they could be missing some learning opportunities.

Inspector's evidence

The pharmacy had put procedures in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines counter, notices on the door and was restricting access to three people at a time. The floor was marked to help people maintain a social distance. People coming to the pharmacy wore face coverings, but team members did not wear masks. They explained that most of the time they were able to maintain two metres from each other. As it was not possible to socially distance during the inspection the inspector asked them to wear masks. They put on their own face coverings. They also washed and sanitised their hands regularly and cleaned surfaces. But the inspector noticed a visible difference when she cleaned the surface prior to placing her equipment on it. The pharmacy had not carried out formal personal risk assessments with team members to identify any risk that may need to be mitigated in the pharmacy. But the pharmacist owner explained that she knew all team members well and had not identified any risks.

The pharmacy had standard operating procedures (SOPs) which team members followed. Although they did not document date checking the way the SOP stated. The pharmacist had reviewed and updated these since the previous inspection. Pharmacy team members had read them, and the pharmacy kept records of this. They were much clearer and defined team members' roles in a better way. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. This was an improvement from the previous inspection, and improved safety. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members sometimes used near miss logs to record dispensing errors that were identified in the pharmacy, known as near miss errors. They had implemented this process following the last inspection, but during the pandemic had not used them consistently. And they had not undertaken formal reviews to identify trends and minimise the chances of the same error happening again. They also recorded errors reaching patients to learn from them, although these were rare. Team members had put labels on shelves to identify items requiring special care e.g. there was a label beside the methotrexate tablets reminding the team that it was a weekly not daily dose.

The pharmacy had a complaints procedure and welcomed feedback. It had a sign on the wall advising people how to feedback to the pharmacy. The pharmacist was working with the GP practice to improve its use of marking 'urgent' on prescriptions. Some were marked as 'urgent' when they were not. And people were not collecting them. So, the pharmacist spent time chasing these up with people. The pharmacy had also liaised with NHS Grampian about the way some electronic notifications were

displayed.

The pharmacy had an indemnity insurance certificate, expiring 30 April 21. The pharmacy displayed the responsible pharmacist notice and accurately kept the following records: responsible pharmacist log, private prescription records including records of emergency supplies and veterinary prescriptions, unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited, except methadone, and a CD destruction register for patient returned medicines. The inspector checked a few balances and they were correct. Team members signed any alterations to the records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read information and the pharmacist had coached them. The topic had also been covered in coursework. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read information on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. They were planning to put this information on the dispensary wall for ease of access.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members either trained or completing appropriate training, to provide safe services. They can make decisions within their competence to help people. Inexperienced team members are adequately supported and know how to raise concerns or seek guidance if required. The pharmacy does not always set aside time for team members to continue their learning so they may find it difficult to keep their knowledge up to date. Team members know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist who was the owner, one full-time pharmacy technician, one part-time dispenser and three medicines counter assistants (36, 30 and 22 hours). One was also the delivery driver. The technician displayed her certificates of qualification. The other team members were undertaking accredited training, two were doing a joint dispensing and medicines counter course and the other was doing a medicines counter course. The pharmacy gave them time during the working week to complete their training, although during the pandemic this had not been possible as often as planned. Typically, there were two team members working at most times. At the time of inspection, the pharmacy technician, a trainee dispenser and the pharmacist were working. They were able to manage the workload.

Trainee team members were supervised by the pharmacist and supported by the pharmacy technician. The pharmacy had begun to introduce regular learning and development after the previous inspection, but this had not been fully implemented yet due to challenges on time through the pandemic. Team members had access to Numark training modules. And they had all read GPhC standards for registered pharmacy premises and discussed them.

Team members were observed going about their tasks in a systematic and professional manner. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacy technician explained how she made decisions within her competence and advised and supported locum pharmacists in the pharmacist owner’s absence. She knew most of the people who used the pharmacy so was able to share relevant information about their medicines and expectations.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the owner. Several months previously a team member had suggested storing multi-compartment compliance packs in a different way. The pharmacist had agreed and adopted this. The pharmacy team members did not have structured meetings but discussed any issues that arose while they were working. Examples included stock availability and requests for certain medicines. Team members had read Numark training modules on whistleblowing since the last inspection. The pharmacy did not set targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy’s services. The pharmacy has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed.

Inspector's evidence

These were small premises incorporating a retail area, dispensary and large back shop area including storage space and staff facilities. There were sinks in the dispensary and toilet. These were clean and had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk and chairs. It was used to store some retail stock. The door closed providing privacy. The pharmacist used it to supervise self-administration of some medicines. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to readily access its services. It provides safe services. Team members support people by providing them with information and advice to help them use their medicines safely. And they provide extra written advice to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a low step and an automatic door. It listed its services and had leaflets available on a variety of topics. A team member who spoke Polish was able to help some Polish members of the local community. She always translated for the pharmacist so that she was aware of any advice being given. The pharmacy provided a weekly delivery service and people usually signed to acknowledge receipt of their controlled drugs, but in the interests of infection control they were not being asked to sign during the pandemic. Social distancing and hygiene measures were in place. Team members additionally delivered locally on foot if medicines were needed urgently. If people did not answer their door, a second attempt was made to deliver later in the day. The team member making deliveries alerted the pharmacist to failed deliveries. And the pharmacist notified the GP. This seldom happened. During the pandemic there had been increased demand for deliveries so the pharmacy had provided details of volunteers who could be contacted by people.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. This was an improvement since the last inspection and improved safety by separating people's medicines. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day. A trainee team member often placed dispensed medicines into bags and handed them out, under the pharmacist's supervision and one person at a time. She asked for information such as an address or date of birth to ensure medicines were given to the correct person. This was also an improvement from the last inspection when usually there was no identity check, with the risk that a person could receive the wrong medicine.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy kept comprehensive records of medicines supply so it could monitor compliance. The pharmacist usually synchronised medicines when people started on serial prescriptions by asking them to bring their medicines in for destruction. But she had not been doing this during the pandemic due to infection risk. The pharmacy managed multicompartment compliance packs on a four-weekly cycle with four assembled at a time. It ordered prescriptions after the second pack was supplied giving plenty time to prepare packs. Team members included tablet descriptions on packs and supplied patient information leaflets unless people had asked them not to. The pharmacy kept a chronological list of changes and interventions in a notebook with a page per person. But it did not record the date of the change or who had requested it, so it would be difficult to refer to this later if required. This was discussed and advice given. The pharmacy supplied a variety of other medicines by instalment. The pharmacist dispensed them, and a team member checked.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had no people in the high-risk group. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and emergency hormonal contraception (EHC). The pharmacy was providing the Pharmacy First service. Team members referred most requests to the pharmacist who used the formulary to provide treatment if required. Team members were not yet empowered to deliver the service as they had not undertaken any training on this new service. But they were providing it in a similar way to the previous minor ailments service. The pharmacist usually provided the smoking cessation service but there was no-one accessing it currently. During the pandemic she had undertaken some consultations for services such as the treatment of urinary tract infections (UTI) and the provision of EHC by phone to limit the use of the consultation room, and the time people spent in the pharmacy. She had occasionally used the consultation room to see people if necessary.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, AAH and OTC Direct. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the equipment on the premises, but team members had not had any training yet. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge and team members monitored minimum and maximum temperatures. They took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the delivery of its services. It looks after its equipment.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept a carbon monoxide monitor for the smoking cessation service in the back-shop area. It was maintained by the Health board and was not being used currently as part of infection control measures. The pharmacy kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. And it had tablet and capsule counters in the dispensary. The team washed these if they were used for cytotoxic tablets. But they were usually supplied in blister packs.

The pharmacy stored paper records in the dispensary and back-shop areas inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.