General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ferryhill Pharmacy, 9 Millburn Street, ABERDEEN, Aberdeenshire, AB11 6SS

Pharmacy reference: 1041628

Type of pharmacy: Community

Date of inspection: 05/03/2024

Pharmacy context

This is a community pharmacy located close to Aberdeen city centre. Its main activity is dispensing NHS prescriptions to people across the city. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. The pharmacy offers a medicines delivery service and provides substance misuse services. It also offers private services which includes travel consultations and chickenpox vaccines. The pharmacy team advises on minor ailments and medicines' use.

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

Pharmacy team members follow safe working practices. And they manage dispensing risks to keep services safe. They mostly keep the records they need to by law correct, and they safely keep people's private information. The team is adequately equipped to manage any safeguarding concerns to help vulnerable people. Team members learn from mistakes they make while dispensing to reduce the risk of further mistakes.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to define the pharmacy's working practices. The SOPs covered tasks such as the dispensing of prescriptions and selling over-the-counter medicines. These were prepared by the superintendent pharmacist (SI) but were past the review date of November 2021. Team members described their roles within the pharmacy and the processes they were involved in. But they had not signed to confirm they had read and agreed to the procedures.

The pharmacy kept a folder to record dispensing mistakes that were identified in the pharmacy, known as near misses. But the last entry was made over six months before the inspection. The responsible pharmacist (RP) explained that any mistakes were discussed informally within the team at the time of the incident but had not been documented. Team members explained that after an error, they would implement actions to reduce the likelihood of a similar error happening again. And gave examples of errors caused my medicines which had similar names and packaging, for example Sando-K and Phosphate-sandoz. The team had separated the medicines to reduce the recurrence of this type of error. They were able to describe the process for recording errors that had been identified after people received their medicines. And that the SI would be informed of any of these dispensing incidents. The team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the SI.

The pharmacy had current professional indemnity insurance. The pharmacy displayed the correct responsible pharmacist notice and had an accurate responsible pharmacist record. From the records seen, it had accurate private prescription records including records about emergency supplies and veterinary prescriptions. The pharmacy received a regular private prescription from one prescriber which was sent by email. But the pharmacy did not always receive the original signed prescription as legally required. The SI stated he would ensure this was rectified with immediate effect. The pharmacy kept digital controlled drug (CD) records with running balances. A random balance check of three CD's was carried out during the inspection. But the physical stock of one did not match the record and was found to be due to a missed entry. The pharmacy checked balances against physical stock when medication was dispensed or received from the wholesaler. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. The pharmacy backed up electronic patient medication records (PMR) to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste from general waste. No person-identifiable information was visible to the public. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. And gave examples of following this process with people who had presented in the pharmacy. They

knew how to raise a concern locally and had access to contact details and processes.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload well and support each other as they work. And they feel comfortable raising concerns if they need to.

Inspector's evidence

The pharmacy employed one full-time pharmacist who was also the manager. It also employed a full-time dispenser, a trainee dispenser and a full-time medicines counter assistant. An undergraduate pharmacy student provided extra cover when required. The SI worked in the pharmacy three days each week and was also present during the inspection. Team members were seen to be managing the workload. They demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. Team members were observed to work on their own initiative, for example to phone the GP practice to suggest other options for medication that was out of stock. Team members were able to rotate tasks so that all tasks could be completed effectively during absence periods.

The pharmacy provided team members undertaking training with protected time during the working day to complete coursework. The trainee dispenser was observed being supervised in their role and described the training support they had received from the RP. All team members were also given time to undertake regular training and development. And they gave examples of recent modules they had completed. Team members asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with requests such as repeated purchases of strong painkillers.

Team members had daily informal discussions as they worked relating to issues such as workload and stock issues. They did not receive formal appraisals with the pharmacist manager. They felt comfortable to make suggestions and raise concerns to the pharmacist or SI. The dispenser explained she had been enrolled on the accuracy checking for dispensing assistant's course and had now submitted the final module for the course. This had been planned with the SI to allow the pharmacist more time to offer services in the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. They are modern, clean and well maintained. And the pharmacy has a suitable, sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

These were bright and modern premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy's overall appearance was professional. It had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions.

People in the retail area were not able to see activities being undertaken in the dispensary. There was a hatch between the dispensary and front shop area. This had reflective glass which made it difficult to see into the dispensary but allowed the pharmacist to supervise the medicines counter. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed which provided privacy. It provided a suitable environment for the administration of vaccinations and other services. The pharmacy also had a separate screened area at the end of the medicines counter which was used for specialist services such as supervising medicines consumption. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which it makes accessible to people. And it manages its services well to help people look after their health. The pharmacy sources, stores and manages medicines safely. This ensures that the medicines it supplies are fit for purpose. And the pharmacy team provides appropriate advice to people about their medicines.

Inspector's evidence

The pharmacy was accessed by means of a small step from street level and the centre of the pharmacy counters were low in height. The pharmacy advertised some of its services and its opening hours in the main window. The pharmacy provided a delivery service. A team member prepared the day's deliveries and kept these in a separate defined area in the dispensary. People were not asked to sign on receipt of their delivery. Team members sent a text message to people who were due to be delivered that day, so they knew to expect it. And any medication which was not delivered was brought back to the pharmacy and a further text message was sent to let people know the pharmacy had attempted delivery. This meant team members could see which deliveries were due and was useful if people called the pharmacy asking about their expected delivery.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and to separate people's medicines and prescriptions. And they attached labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines.

The pharmacy supplied medicines in multi-compartment compliance packs to people who needed extra support with their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person which documented the person's current medicines and administration time. They maintained notes of previous changes to medication, creating an audit trail of the changes. Packs were labelled so people had written instructions about how to take their medicines. These labels included descriptions of what the medicines looked like, so they could be identified in the pack. Team members provided people with patient information leaflets about their medicines when they first received their pack. And if their medication changed. Shelving to store the packs was kept neat and tidy. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and kept the medicines in individually-named baskets on shelves. They kept a record of the date of each supply.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these on an eight-weekly cycle. They maintained records of when people collected their medication. This meant the pharmacist could then identify any potential issues with people not taking their medication as they should. The pharmacy notified the GP practice for a further prescription when all episodes of the prescription were collected. And they added notes of any care issues identified. This helped make sure people's medicines were reviewed by their GP appropriately.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving higher-risk medicines which included including methotrexate and lithium. People were supplied with written information and record books if required. Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. They dispensed one person with valproate in instalments out of the original pack. The pharmacist explained they were not in the at-risk group and had assessed the risk of dispensing in this way for the individual.

The pharmacy had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation and emergency hormonal contraception (EHC). The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required. The SI was an independent prescriber and provided the NHS Pharmacy First Plus service. They treated several common clinical conditions including those affecting the ear, nose and throat. They were trained to carry out clinical examinations and worked to a national service specification and prescribed to a local formulary. They used NHS prescriptions with a unique prescriber number so their prescribing activity could be reviewed and audited. Local GP teams were aware of the service and signposted people to the pharmacy. The SI recorded the consultations on the PMR. But some of the consultation entries seen contained limited detail which may make it difficult to refer back to if there was a query. The SI sent a summary of the consultation to the person's regular GP. The SI also provided private prescribing services. This included vaccinations for travel, chickenpox and shingles. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used.

The pharmacy supplied medicine to several people daily as supervised and unsupervised doses and used automation with a pump linked to a laptop to prepare the doses. The team inputted prescription data into the system to ensure the pump measured the required doses and printed labels. Team members regularly checked and cleaned the pump to ensure the correct doses were measured on each occasion. The pharmacy administered injectable treatment to some people requiring treatment for substance misuse. The pharmacist had attended local specialist training for the service. They administered the injection under agreement with the local addiction team and monitored people after the injection. They kept records of administration and worked collaboratively with the local addiction team to ensure that all parties were aware when treatment had been given.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Team members regularly checked expiry dates of medicines. But they did not make a record of these checks. A sample of approximately twenty random medicines identified two date-expired medicines, which were kept in the rear stock room and CD cabinet respectively. The RP agreed to ensure these areas were included in ongoing regular checks. The pharmacy had disposal bins for expired and patient-returned stock.

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 resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had internet access allowing access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a blood pressure meter and otoscope. Team members kept clean crown-stamped measures by the sink in the dispensary and cleaned these after each use. The pharmacy used an automated pump for measuring doses on a daily basis. Team members cleaned it at the end of each day and poured test volumes each morning. The pharmacy team kept clean tablet and capsule counters in the dispensary. The pharmacy stored paper records in a locked filing cabinet in the consultation room inaccessible to the public.

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.