

Registered pharmacy inspection report

Pharmacy Name: Garthdee Pharmacy, 7 Ramsay Crescent, Kaimhill,
ABERDEEN, Aberdeenshire, AB10 7BL

Pharmacy reference: 1041634

Type of pharmacy: Community

Date of inspection: 28/05/2019

Pharmacy context

This is a community pharmacy on a shop parade in a suburb of a city. Local people of all ages use the pharmacy. The owner works in the pharmacy full time. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs.

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 processes for all services to ensure that they are safe. They record mistakes to learn from them. And they make some changes to avoid the same mistake happening again. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place and these were followed for all activities and tasks. These had been read and signed by relevant staff members except for a summer student who had started in the pharmacy the previous week. The pharmacist explained that she would read and sign these in a phased manner over coming days and weeks. The SOPs were reviewed every 2 years by the superintendent (SI) pharmacist. He had not made changes, and the same documents had been in place for several years. Staff roles and responsibilities were recorded on individual SOPs. The pharmacy had a business continuity plan in place to address maintenance issues or disruption to services.

Dispensing, a high-risk activity, was observed to be methodical with coloured baskets in use for dispensing. Pharmacy team members signed dispensing labels to provide an audit trail of who had dispensed and who had checked medicines.

The pharmacy kept near miss logs and recorded any errors reaching patients. The pharmacist reviewed these informally and had put some strategies in place to reduce the risk of repeat incidents. For example, he had placed labels in front of inhalers to draw attention to different devices, and separated tramadol and trazodone on shelves.

Staff members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist.

The pharmacy had a complaints procedure although it seldom received complaints. Team members obtained items that the pharmacy did not normally stock on request. A team member described trying to give advice and information in a more succinct manner following feedback that she was giving too much information.

An indemnity insurance certificate was displayed, expiring in August 2019.

The pharmacy kept the following records in compliance with relevant legislation: responsible pharmacist notice was displayed; responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records and controlled drugs registers, with running balances maintained and regularly audited. the pharmacy kept a controlled drug (CD) destruction register for patient returned medicines. The pharmacy had some items in a cabinet that had not been recorded on receipt. The electronic patient medication records (PMR) were backed up each night.

Team members were aware of the need for confidentiality and most had signed an SOP. No person

identifiable information was visible to the public. The pharmacy segregated confidential waste and shredded it.

Team members had also signed an SOP on safeguarding, although this was quite an old document. The pharmacy had safeguarding information produced by the Royal Pharmaceutical Society, but this document was dated 2007 and had previous address information.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. Team members take part in some training and share information with each other. They discuss incidents and errors and they learn from them to avoid the same thing happening again.

Inspector's evidence

Staff numbers in the pharmacy: one full-time pharmacist (owner) and a regular locum pharmacist covering days off, one full-time pharmacy technician and one part-time dispenser who worked variable hours, 20-30 per week depending on need. The pharmacy also had two pharmacy students, one working Saturday mornings and Wednesday afternoons during term time, and the other working full-time over the summer holiday. She had started in the pharmacy the previous week. The preregistration pharmacist was currently on study leave and soon to leave the pharmacy. At the time of inspection, there was a pharmacist, pharmacy technician, dispenser and pharmacy student working, and they were able to manage the workload. Staffing levels and workload were monitored and the part-time dispenser worked variable hours as required. Her flexibility and the part-time students covered absence.

The pharmacy did not have structured training and development in place. The pharmacy technician and dispenser were experienced and read information on new services and new products as it came into the pharmacy. They sometimes attended local events run by drug companies or the NHS. Sometimes one team member attended events and shared information with others. They described 'on the job' coaching and discussions, often following drug company representatives visiting the pharmacy. Team members described examples such as new inhaler devices being discussed. They sometimes watched or listened to podcasts.

The various individuals were observed going about their tasks in a systematic and professional manner. They were observed to ask appropriate questions when selling medicines over-the-counter. They were all aware of items of abuse and examples were described of referring people to the pharmacist who were requesting repeat purchases.

Team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They described how they discussed these openly as they occurred. The pharmacy did not hold formal meetings, but as this was a small team and individuals worked together frequently, there was open discussion throughout the working day. The team members knew how to contact the NHS controlled drugs authorised witness and accountable officer to raise any concerns. The pharmacy did not have targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is safe and clean and suitable for its services. The pharmacy usually protects people's information. It is secure when closed.

Inspector's evidence

The pharmacy was of average size although the dispensary was small. It had a room to the rear where tasks such as the management of multi-compartmental medicines packs and instalment prescriptions, including methadone were undertaken.

There were sinks in the dispensary and toilet. These had hot and cold running water, soap, and clean hand towels. The premises were observed to be clean. The pharmacy was old-fashioned and would benefit from modernisation. It had an area of damp, which had been treated but had recurred following a leak from above. Medicines were not stored in this area.

Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. The pharmacy had a consultation room, which was also used as an office and staff area with a desk, chairs, and computer. It was used mostly as an office and was untidy. People receiving medicines by supervised consumption were taken into an area of the dispensary. The pharmacist took care to minimise any visible person identifiable information.

Temperature and lighting were comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and power assisted door. It displayed a list of its services. And it had Leaflets on a range of topics. It had a hearing loop in working order.

Dispensing work flow was logical and managed in a linear manner with team members using coloured baskets to segregate each patient's medicines and prescriptions. The dispenser or pharmacy technician labelling told the pharmacist if there were any changes or omissions to prescriptions. Team members signed dispensing labels to provide an audit trail of who had dispensed and checked medicines. The pharmacy usually assembled owings later the same day, or the following day. The pharmacy provided a delivery service and people signed on receipt of the medicines.

Team members managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. They undertook this activity in the room behind the dispensary where there was little distraction or interruption. They included tablet descriptions on labels and they supplied patient information leaflets (PILs) with the first pack of each prescription unless patients had signed a document requesting not to receive these. The pharmacy stored completed trays in individual boxes per patient in the consultation room.

The pharmacist poured methadone instalments. He used a MethaMeasure device and poured instalments for people being supervised as they arrived at the pharmacy. He poured takeaway doses up to a week in advance and stored these in a controlled drug (CD) cabinet. The pharmacy re-used bottles that were not handled by people and these were stored on shelves in the rear dispensary with labels on them for forthcoming supplies. When people arrived at the pharmacy for their supervised dose, the pharmacist invited them into an area of the dispensary where they could not be seen by other members of the public. The pharmacist managed this appropriately, preventing other people's information or methadone bottles being seen. He confirmed people's identity and asked what dose they were expecting to ensure the correct dose was supplied. The pharmacist acknowledged that this was not the ideal arrangement. He explained that this was better than having to walk through the front shop with methadone instalments to the consultation room which was not set up for this activity. There were a variety of other medicines supplied by instalment. The dispenser usually dispensed these and they were checked by the pharmacist then stored methodically on shelves in the rear area.

Clinical checks were undertaken by a pharmacist and people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin were given appropriate advice and counselling. Written information and record books were provided if required. The valproate pregnancy prevention programme was in place. Team members described one person on this medication who was forgetful. They had discussed this with her on several occasions but were sensitive as she was often in the

pharmacy with friends. They explained that another person had been identified but didn't fit the criteria, and another had been changed onto another medication. The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. The pharmacist also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy had some additional clinical information on the wall of the office as an aide memoir e.g. information on drugs affected by a person's smoking status.

The pharmacy followed the service specifications for NHS services and had patient group directions (PGDs) in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and chloramphenicol ophthalmic products. Chronic medication service (CMS) serial prescriptions were dispensed when people phoned requesting them. The pharmacy technician checked computer records daily to monitor compliance. She had not found any examples of poor compliance. When people were started on serial prescriptions, a team member asked them to bring all their medicines into the pharmacy and they were synchronised. The preregistration pharmacist who was not present during inspection had been undertaken registrations over the past year. Team members present were not aware of any pharmaceutical care issues identified. All team members were empowered to deliver the minor ailments service (eMAS) within their competence. The preregistration pharmacist had been delivering the smoking cessation service and had recently passed this to the pharmacy technician. The pharmacy currently had four people accessing the service and all were prescribed nicotine replacement therapy. The pharmacy technician described some recent successes.

The pharmacy got medicines from licensed suppliers such as Alliance and AAH. The pharmacy did not yet comply with the requirements of the Falsified Medicines Directive (FMD). It had the hardware on the premises, but the software provided by Positive Solutions was not yet working.

The pharmacy undertook regular date checking of medicines and items inspected were found to be in date. It stored medicines in original packaging on shelves and in cupboards, and items requiring cold storage were stored in a large fridge. Team members monitored and recorded minimum and maximum temperatures and took appropriate action if there was any deviation from accepted limits. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these medicines.

They actioned MHRA recalls and alerts on receipt and kept records kept. And they contacted people who they had supplied with medicines subject to a patient level recall. Pharmacy returned any 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 delivery of its services. It looks after this equipment to ensure it works.

Inspector's evidence

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

The pharmacy had a carbon monoxide monitor which was maintained by the health board. And it had approved BS and crown stamped measures which were washed after use, and tablet and capsule counters, including a separate marked one for cytotoxic tablets. The MethaMeasure pump device was cleaned daily and test volumes poured each morning.

The pharmacy stored paper records in the dispensary and in files in the consultation room, where they were not visible to people. Team members did not leave computers unattended and they used passwords. Members of the public were not able to see computer screens. Team members took care to ensure phone conversations could not be overheard.

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.