

Registered pharmacy inspection report

Pharmacy Name: Albyn Pharmacy, 156 Union Grove, ABERDEEN,
Aberdeenshire, AB10 6SR

Pharmacy reference: 1041641

Type of pharmacy: Community

Date of inspection: 10/04/2019

Pharmacy context

This is a community pharmacy set in a row of shops in a suburb of a large city. The pharmacy dispenses NHS prescriptions, private prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartment medicine devices. Other services that the pharmacy offers include chronic medication service (CMS), minor ailments service (eMAS), travel vaccination and flu vaccination during the flu season.

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.

The pharmacy keeps the records that it needs to by law. And keeps people's information safe.

Inspector's evidence

Standard operating procedures (SOPs) were in place and followed for all activities/tasks. They had been read and signed by relevant staff members. But they were written in 2016 and due for review in 2018.

Dispensing, a high-risk activity, was observed to be appropriately managed with coloured baskets in use for dispensing. There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels.

The pharmacy displayed a list of jobs to be done each day, and each Saturday. This was to make sure that all tasks were done as they should be. Business continuity planning was in place to address maintenance issues and disruption to services. The pharmacy had a list of preferred contractors with their contact details. And it had a list of phone numbers for GP practices, suppliers and the other branch in the organisation.

Near miss logs were kept and error reporting was in place. Pharmacy team members did not make many mistakes, so not many near misses were recorded. Team members discussed incidents at the time. They did not regularly review these as they felt there were not enough records to have meaningful review.

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

There was a complaints procedure in place. Team members were not aware of any complaints. They described ordering items in for people on request e.g. vitamins and Colpermin. Some people preferred certain brands of medicines and the pharmacy always supplied these. Team members put notes on to people's records as a reminder.

The pharmacy had indemnity insurance, provided by Numark, expiring 29 June 2019. The following records were maintained in compliance with relevant legislation: responsible pharmacist notice displayed; responsible pharmacist log; private prescription records, including records of emergency supplies and veterinary prescriptions. This record was not inspected as team members present during inspection were unable to access the electronic register. Unlicensed specials records were not seen as the dispenser didn't know where they were kept, but she described how they were dealt with. Controlled drugs registers, with running balances maintained and regularly audited, except methadone solution. Records of patient returned controlled drugs patient medication records (PMR) were backed up every night. The pharmacist initialled alterations to records, so these were attributable.

Team members were aware of the need for confidentiality. But they were not aware of any policy or

standard operating procedure. No person identifiable information was visible to the public. Confidential waste was shredded.

Members were aware of safeguarding issues. And they had read an SOP in the other branch, but had not seen it in this pharmacy. The pharmacist knew that local processes and contact details were on the Community Pharmacy Scotland website. She was Protection of Vulnerable Groups (PVG) registered.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy has enough qualified and experienced staff to safely provide services. Team members have access to training material to ensure that they have the skills they need. They can share information and know how to raise a concern if they had one.

Inspector's evidence

Staff numbers on the day of the inspection included: one full-time pharmacist manager, who had worked in the pharmacy for several years; one full-time dispenser, currently working five and a half days per week; and one part-time delivery driver. Recently a Saturday only pharmacy student had left, so the dispenser was working Saturdays until a replacement had been recruited. At the time of inspection, the dispenser and a locum pharmacist were working. They were observed to manage the workload.

Dispenser had started in this pharmacy two months ago. He had a lot of dispensing experience, and had been working in the other branch in the organisation until then. There were plans for her to start technician training when the pharmacist manager returned from annual leave.

Staff absence was covered from the other branch in the organisation which was close by. The dispenser explained that she would contact the superintendent pharmacist as soon as possible, possibly the evening before using social media if she was planning being absent.

'Counter skills' and other training material was read as received. The dispenser described being interested in delivering naloxone training to people, and was planning being trained to do this. Staff development meetings were planned over the next few weeks, so this training would be discussed then.

Pharmacy team members were observed going about their tasks in a systematic and professional manner. They demonstrated a good manner with people. Both team members asked appropriate questions when buying medicines. Good advice was offered to a person using personal weighing scales, ensuring they were being used correctly.

The team members were comfortable owning up to mistakes and sharing with colleagues to avoid repeating incidents and learn from these. Dispenser described sharing experiences from her previous role, and the pharmacist being receptive to these. She described examples related to chronic medication service (CMS) prescriptions, and managing tablets removed from multicompartiment compliance devices.

The dispenser described the pharmacist, and superintendent pharmacist being approachable. So, she would be able to raise concerns. She explained that there was a lot of information sharing and discussion 'on the job'. The pharmacy did not set targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are safe and clean, and suitable for the services it provides. Pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy is secure when closed.

Inspector's evidence

This was a small pharmacy premises with a small dispensary, retail area and minimal staff facilities. There were sinks in the dispensary, and toilet area. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The premises were observed to be clean, hygienic and well maintained.

Prescription medication waiting to be collected was stored in a way that prevented people's details being seen by any other people.

There was a consultation room with a desk, chairs, and sink which was clean and tidy and the door closed providing privacy. It had a hatch to the dispensary. The pharmacy had an alarm and CCTV. A window to the rear of the premises was protected by bars. Temperature and lighting were comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy makes some changes to its processes to help people to ensure they can use its services and take their medicine correctly. The pharmacy team provides safe services. Team members give people information to help them use their medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy had a step at the entrance. But there was good visibility from the dispensary, and help was given when needed. The pharmacy displayed a list of the services it provided. It had a hearing loop in working order. The dispenser described some strategies used to help people with their medicines. This included providing large print labels for people with impaired vision, breaking large tablets in half for a person unable to swallow them whole, and reconstituting a medicine for a person unable to do this. The pharmacy had leaflets on a range of topics available.

The pharmacy had a logical and smooth dispensing workflow. The pharmacist usually labelled and clinically checked prescriptions, then the dispenser assembled these. When the dispenser labelled, she shared information with the pharmacist, such as changes in medication.

Dispensing audit trails were in place with initials on dispensing labels of personnel who had dispensed and checked medicines. Owing were usually assembled later the same day or the following day. The pharmacy provided a delivery service. People signed to show that they had received controlled drugs. Items requiring cold storage were not delivered.

Multi-compartment medicine devices were managed on a four-weekly cycle with four assembled at a time. The pharmacy kept thorough records of these, including progress logs. Tablet descriptions were written on to labels and patient information leaflets (PILs) were supplied with the first device of each prescription.

The pharmacy supplied medicines to people living in two small residential units. Some people got their medicine in multi-compartment devices, and some got original packs.

The pharmacist usually poured methadone instalments, and the dispenser checked these. They were stored in a controlled drug cabinet in bags with the person's name and date of supply on them until they were collected.

There were a variety of other medicines supplied by instalment, dispensed in their entirety by the dispenser, and checked by the pharmacist. Instalments were placed in individual bags with name and date of supply on them.

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 dispenser was aware of the valproate pregnancy prevention program, and 'sick day rules' for people taking certain medicines.

Private prescriptions were received by email from a skin clinic for isotretinoin. There was a pregnancy prevention program in place for this medication, and the dispenser was familiar with it. The prescribing

doctor noted on the prescription that pregnancy tests had been carried out and were negative. The dispenser gave appropriate responses to scenarios posed. The pharmacy received the original prescriptions weekly and all legal records were kept. The pharmacist contacted the prescriber by phone if there was not a note regarding a pregnancy test, or if there were any unusual doses.

Dispensed medicines were packaged using 'bubble wrap', then posted using a tracked service. NHS services followed the service specifications and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, chloramphenicol ophthalmic products and chlamydia treatment. These were current and the pharmacist had been trained and signed them.

Private PGDs were in place for travel vaccination. The pharmacist had undertaken all relevant training recently and kept robust records of patients and vaccines used. Consultations were comprehensive and the pharmacist thoroughly researched requirements and discussed them with people.

There were several patients receiving medicines on chronic medication service (CMS) prescriptions. These were dispensed when patients presented. The pharmacist knew all the patients and there was no evidence of compliance issues. The pharmacy did not have a system in place to monitor compliance. The pharmacist had not identified any pharmaceutical care issues. He was meeting with the local GP practice to discuss changes to this service.

The dispenser was empowered to deliver the minor ailments service (eMAS) within her competence. The pharmacist could overhear conversations due to the layout of the premises. This was a popular service.

The pharmacy provided the Lipotrim[®] weight management program. People came to the pharmacy weekly and the pharmacist undertook the initial consultation. Subsequent consultations were undertaken by either pharmacist or dispenser. The pharmacist spent time with people giving them nutrition and general fitness advice.

Pharmacy had a wholesale dealer license, and this had no impact on people. Invoices were observed from licensed suppliers. The pharmacy did not comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacist was liaising with the software provider, and the scanner was available in the pharmacy. There were no SOPs or training in place.

Records of date checking and stock rotation were observed, and items inspected were found to be in date. Medicines were stored in original packaging on shelves/in drawers. There were some loose tablets in bottles with inadequate labelling. Pharmacist had separated some medicines to improve the layout and increase safety. Analgesics were in a separate area on labelled shelves. Diazepam tablets were in labelled drawers with each strength kept separately. Items requiring cold storage were stored in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Controlled drugs (CDs) were stored in an approved CD cabinet. Pharmacy (P) medicines were protected from self-selection, as they were behind a counter. Sale of P medicines was as per sale of medicines protocol. Prompt cards and an aide memoir from NHS education for Scotland (NES) situated at the medicines counter for reference.

MHRA recalls and alerts were actioned on receipt. Patients were contacted following patient level recalls. The pharmacy was printing patient information leaflets for a batch of chloramphenicol eye drops following notification that the enclosed leaflet was incorrect. Items received damaged or faulty were returned 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. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

Texts available in the pharmacy included current editions of the British National Formulary (BNF) and BNF for Children. The pharmacy had internet access allowing online resources to be used.

ISO and Crown stamped were kept by the sink in the dispensary, and separate marked ones were used for antibiotics. Clean tablet and capsule counters were also kept in the dispensary, and a separate marked one was used for cytotoxic tablets.

The pharmacy had the materials it required for posting medicines. Paper records were stored in the dispensary. Computers were never left unattended and were password protected. Screens were not visible to the public. Care was taken 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.