

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: 18/07/2023

Pharmacy context

The pharmacy is on a parade of shops in a residential area in the city of Aberdeen. Its main services include dispensing of NHS prescriptions, and it dispenses some medicines in multi-compartment compliance packs to help people take their medicines properly. Team members advise on minor ailments and medicines use. And they deliver the NHS Pharmacy First service.

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	1.8	Good practice	The pharmacy has a clear culture of safeguarding children and vulnerable adults. And it supports its team members in raising concerns. It advertises to people how team members can help. And its team members have confidence and experience to suitably protect vulnerable people's welfare.
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 appropriately manages the risks associated with the services it provides for people. Its complete set of written procedures help the team carry out tasks consistently and safely. And team members suggest ideas to improve the written procedures. They record and learn from the mistakes they make when dispensing. And they keep the records they need to by law. Team members have knowledge and experience to help support vulnerable people. And they work well together to protect people's welfare.

Inspector's evidence

The pharmacy had a set of comprehensive standard operating procedures (SOPs) to help team members manage risks. Team members had read the SOPs relevant to their role and completed a record of competence signature sheet to confirm their understanding of them. The SOPs were due to be reviewed and team members had provided input into the development of the SOPs. A team member had suggested dispensing medication requiring cold storage into clear bags prior to collection instead of a paper bag. The clear bag enabled an additional check to be completed of the medication against the prescription at the point of collection, helping reduce the risk of an error involving medicines such as insulin. The responsible pharmacist (RP) advised the new process was being incorporated into the upcoming review of the relevant SOP. Team members were observed working within the scope of their roles. They were aware of the RP regulations and of what tasks they could and couldn't do in the absence of an RP.

Pharmacy team members recorded mistakes they identified during the dispensing process, known as near misses on a paper near miss record. They explained errors were highlighted to them by the pharmacist, and it was their responsibility to enter it onto the record. This allowed them to reflect on the mistake. The pharmacist manager reviewed the near miss record regularly to identify any trends and patterns. A common trend found from this analysis included an increase in the incorrect formulation of medicines being dispensed. Team members had separated the storage of medicines of the most common errors, for example metformin tablets and metformin modified release tablets, to reduce the recurrence of this type of error. They also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. These incidents were recorded in the pharmacy, shared with the local Health Board, and were then reviewed by the superintendent (SI).

A suggestion box was in place in the retail area for people to provide feedback and to rate their experience of pharmacy services. The feedback was reviewed by the team and a recent example described the service as being exemplary. Team members aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the manager or SI.

The pharmacy had current professional indemnity insurance. The RP notice displayed contained the correct details of the RP on duty and it could be viewed from the retail area. The RP record was generally compliant, there were some missed sign-out entries observed on the sample of the record examined. The pharmacy held its CD register electronically. And from the entries checked, it appeared to be in order. The team checked the physical levels of CDs against the balances recorded in the CD

register every week. There was a record of patient returned CDs and this was maintained to date. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. Accurate electronic records of private prescriptions were maintained.

Team members were aware of the need to keep people's private information secure. They were observed separating confidential waste into marked bags which were collected by a third-party contractor for secure destruction. The pharmacy stored confidential information in staff-only areas of the pharmacy. A privacy notice was on display in the retail area and there was a sign advertising that the pharmacy had a safe space for vulnerable people. This initiative allowed people experiencing domestic abuse to use the consultation room as a safe space. Pharmacy team members had completed learning associated with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns well and were familiar with common signs of abuse and neglect. They discussed their concerns with the pharmacist, who had on more than one occasion supported people and made onward referrals. The team had access to contact details for relevant local agencies. The pharmacist was a member of the Protecting Vulnerable Groups (PVG) scheme. There was a clear culture of safeguarding in the pharmacy and team members felt supported when dealing with concerns. They felt they had been provided with excellent training on safeguarding and had provided feedback to the accredited course provider.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has sufficient team members with the right qualifications and knowledge to manage its workload and provide its services. And it suitably reviews its staffing profile following changes in workload. The pharmacy supports its team members to complete appropriate training for their role and keep their skills up to date. They work well together and communicate effectively. And they are comfortable providing feedback and raising concerns should they need to.

Inspector's evidence

The pharmacy employed a full-time pharmacist manager who was completing their Independent Prescribing qualification. There was a full-time dispenser, two part-time dispensers, a part-time pharmacy student and a delivery driver. Team members had all completed accredited training for their role. They were observed working well together and managing the workload. Planned leave requests were managed so that only one team member was absent at a time. Team members rotated tasks so that all tasks could be completed effectively during absence periods. Part-time team members supported by working additional hours during periods of planned leave. The staffing levels had been reviewed and additional team members were employed in January 2023 to support with an increase in prescription volume.

A team member had recently completed their accredited training course and had received protected learning time each week to complete this. And they received support from the regular pharmacist. Team members also completed regular ongoing training that was relevant to their roles such as training relating to seasonal ailments such as hay fever treatment and over-the-counter consultation skills. The local Pharmacy First Champion visited the pharmacy monthly and provided training on updates to the NHS Pharmacy First service.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist when necessary. They explained how they would identify repeated requests from people for medicines subject to misuse, for example, codeine containing medicines. And that they would refer repeated requests to the pharmacist. Team members explained that they had received some requests via telephone for codeine linctus. And they reported this to the pharmacist and the local Controlled Drug Accountable Officer (CDAO) via email. The pharmacy received regular alerts from the CDAO regarding fraudulent requests for codeine containing preparations which were shared with the team.

The team attended regular informal team meetings where they discussed safety alerts and any learnings from near misses or dispensing incidents. These meetings were led by the pharmacy manager, and all team members contributed to the meeting. A team member recently suggested a change to the management of serial prescriptions which was implemented, and the team advised this had made it easier to manage this service. Team members felt comfortable to raise any concerns with their pharmacist manager in the first instance. They also felt comfortable to raise any concerns with the pharmacy owner and SI, who visited the pharmacy regularly. Team members received formal appraisals with the pharmacist manager every year where they had the opportunity to identify individual learning needs. There were targets set for some pharmacy services and team members did not feel under pressure to achieve these.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and are appropriately maintained. It has a suitable consultation room where people can have a confidential conversation with a pharmacy team member.

Inspector's evidence

The pharmacy premises were clean and maintained to a high standard. Team members had enough space to dispense medicines. There were clearly defined areas used for the dispensing process and there was a separate bench used by the RP to complete the final checking process located at the side of the dispensary near the retail counter. The medicines counter could be clearly seen from the checking area which enabled the pharmacist to intervene in a sale when necessary. There was a tensor barrier to prevent unauthorised people entering the dispensary. The pharmacy had enough space to store its medicines. A good-sized consultation room was clearly signposted and was locked when not in use. Team members used a hatch between the dispensary and consultation room that was protected by a screen to provide supervision of substance misuse services. There were chairs available in the retail area that provided a suitable waiting area for people receiving clinical services.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and there were other facilities for hand washing. A portable sink was available to use in the consultation room when providing clinical services. The pharmacy kept the room temperature to an acceptable level. And there was bright lighting throughout.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides a range of services that supports local people's health needs. It manages its services well and they are generally accessible to people. The pharmacy receives its medicines from reputable sources and stores them appropriately. The team carries out checks to help ensure medicines are safe to supply.

Inspector's evidence

The pharmacy had a manual door with a small, stepped access. Team members were aware of some people who used a wheelchair that were unable to access the pharmacy. And they provided alternative solutions such as a delivery service. The pharmacy advertised its services and opening hours on the exterior of the premises and in an information leaflet. And there were other healthcare information leaflets were available for people to take away with them. These included information on the NHS Pharmacy First service and Medicines: Care and Review (MCR) service.

The dispensary had separate areas for labelling, dispensing, and checking of prescriptions. Team members used dispensing baskets to store medicines and prescriptions during the dispensing process to prevent them becoming mixed-up. Team members signed dispensing labels to maintain an audit trail. The pharmacy did not routinely provide owing slips to people when it could not supply the full quantity prescribed. This meant people did not always have a record of medicines they had not yet received. Team members advised people of any items owed at the point of collection. Team members contacted the prescriber if the pharmacy could not source a medicine from a manufacturer. The pharmacist also prescribed alternative medications under the Unscheduled Care Patient Group Direction (PGD) where possible. The pharmacy offered a delivery service, and it kept records of completed deliveries.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to avoid covering up written warnings on the packs with dispensing labels. The pharmacy supplied patient information leaflets and patient cards with every supply. Following a recent review, no people were identified in the at-risk group prescribed valproate. Team members attached various alert stickers to prescriptions. They used these as a prompt before they handed out medicines to people who may require further intervention from the pharmacist.

A large proportion of the pharmacy's workload involved supplying people's medicines in multi-compartment compliance packs. This helped people better manage their medicines. Team members used medication record sheets that contained each person's medication and dosage times. They ordered people's repeat prescriptions and reconciled these against the medication record sheet. They documented any changes to people's medication on the record sheets and who had initiated the change. This ensured there was a full audit trail should the need arise to deal with any future queries. The packs were annotated with detailed descriptions of medicines in the pack, which allowed people to identify their medicines. The pharmacy supplied people with patient information leaflets. The compliance packs were signed by the dispenser and RP so there was an audit trail of who had been involved in the dispensing process. The pharmacy also supplied medication administration records (MARs) with the medicines to people who lived in a care home.

Team members managed the dispensing of serial prescriptions as part of the Medicines: Care and Review (MCR) service. The prescriptions were stored alphabetically, and people telephoned the pharmacy to advise that they required their next prescription supply. This allowed the team to dispense medicines in advance of people collecting. The NHS Pharmacy First service was popular. This involved testing and supplying medicines for common clinical conditions such as urinary tract infections under a PGD. The pharmacist could access the current PGDs electronically and had paper-based copies.

The pharmacy stored pharmacy-only (P) medicines behind the pharmacy counter to prevent unauthorised access. It obtained medicines from licensed wholesalers and stored these tidily on shelves. And it used a medical grade fridge to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the accepted range of two and eight degrees Celsius. Team members checked the expiry dates of medicines monthly. Short-dated stickers were used to highlight medicines which were due to expire. The team advised that they were up to date with the process and had an audit trail to demonstrate completion. A random selection of medicines were found to be within their expiry date. The pharmacy received notifications of drug alerts and recalls via email. Team members carried out checks and knew to remove and quarantine affected stock. And they kept a printed record of the action taken. They returned items received damaged or faulty to manufacturers as soon as possible. The pharmacy had medical waste bins. And this supported the pharmacy team to manage pharmaceutical waste.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF) and the BNF for children. And there was access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. There were separate cylinders to be used only for dispensing water which were marked. This helped reduce the risk of contamination. The pharmacy had a set of clean, well-maintained tablet and capsule counters.

The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information. The dispensary was screened, and computer screens were positioned to ensure people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move to a quiet area to have private conversations with people.

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.