General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Duke Street Pharmacy, 26 Duke Street, HUNTLY, Aberdeenshire, AB54 8DL

Pharmacy reference: 1041669

Type of pharmacy: Community

Date of inspection: 20/03/2024

Pharmacy context

This is a community pharmacy in the Aberdeenshire town of Huntly. Its main activity is dispensing NHS prescriptions. It supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. And it supplies medicines to people living in care homes. The pharmacy team advises on minor ailments and medicines' use.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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. Team members recognise and appropriately respond to safeguarding concerns about vulnerable people. They suitably protect people's private information and keep the records they need to by law. Pharmacy team members discuss mistakes they make to learn from them. And they make some records to help them reduce the risk of similar mistakes occurring.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy's working practices. They covered tasks such as the dispensing process and the NHS Pharmacy First service. Team members described their roles within the pharmacy and the processes they were involved in. And accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. The SOPs had been prepared by the superintendent pharmacist (SI) in July 2020 and there were records showing team members had read and agreed to follow them. The SI was in the process of reviewing and updating the SOPs.

Team members kept some records about dispensing mistakes that were identified before the person received their medicines, known as near misses. And they recorded errors that had been identified after people received their medicines. Team members discussed errors when they happened to learn from them. And introduced strategies to minimise the chances of the same error happening again. This included highlighting shelves where medicines with similar names or strengths were stored. So that team members were extra vigilant when selecting these items. But team members did not always complete a record for every near miss they made. And so they may have missed the opportunity to learn form these and identify any trends or patterns. The pharmacy had a documented procedure for handling complaints and feedback from people. Pharmacy team members explained people usually provided verbal feedback. And any complaints were referred to the pharmacist to handle.

The pharmacy had current professional indemnity insurance. It maintained digital controlled drug (CD) registers and kept running balances for all registers. Pharmacy team members audited these balances regularly. Checks of the running balances against the physical stock for three products were found to be correct. The pharmacy kept a register of CDs returned by people for destruction. It maintained an accurate responsible pharmacist record electronically and displayed the correct responsible pharmacist notice. From the records seen, it had accurate private prescription records including records about emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines.

Pharmacy team members were aware of the need to protect people’s private information. They separated confidential waste for secure shredding. No person-identifiable information was visible to the public. The pharmacy displayed a notice in the retail area that told people how it used and protected their personal information. Team members had completed training on confidentiality and data security. The pharmacy had a safeguarding procedure. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. Members of the pharmacy team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person. They were aware of the Ask for ANI (action needed immediately) scheme to help people suffering domestic abuse access a safe place. They knew how to raise a safeguarding concern locally and had access to contact details

and processes.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the necessary qualifications and skills to safely provide the pharmacy's services. They complete some additional training to maintain their knowledge and skills. They manage their workload well and support each other as they work. And they feel comfortable raising concerns. The pharmacy has adequate procedures in place to help its team manage the workload in the event of unplanned staff absence.

Inspector's evidence

The pharmacy employed one full-time pharmacist manager, one full-time dispenser, one part-time dispenser and one full-time medicines counter assistant. The pharmacy displayed their certificates of qualification. Team members were seen to be managing the workload. Team members spoken to during the inspection were experienced in their roles and most of them had been working at the pharmacy for several years. They demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. The manager and SI reviewed staffing levels regularly. Part-time team members had some scope to work flexibly providing contingency for absence. And the pharmacy could request support when needed from the company’s other pharmacy that was a short distance away in the same town.

The pharmacy provided team members with opportunities for ongoing learning and training. Team members accessed e-learning training modules. They had completed recent training on anaphylaxis and the NHS emergency Naloxone service. As they were a small team, they received regular informal feedback as they worked from the manager. They used a notebook to communicate relevant details for other members of the team. And they felt comfortable to raise any concerns with the SI. The team had regular informal meetings to discuss workload plans and updates from the SI.

Team members asked appropriate questions when responding to requests for selling medicines. They demonstrated a clear understanding of medicines liable to misuse and would speak to the pharmacist if they had any concerns about individual requests. They also recognised when the same people made repeated requests and would refer them to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. They are clean, secure, 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 average-sized 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, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy's overall appearance was professional. The pharmacy 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. The pharmacy had a consultation room with a desk, chairs and sink. It 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 door was kept locked to prevent unauthorised access. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services well to help people look after their health. It correctly sources its medicines, and it completes regular checks of them to make sure they are in date and suitable to supply. And the pharmacy team provides appropriate advice to people about their medicines.

Inspector's evidence

The pharmacy was accessed by means of a power-assisted door with a low step from street level. It advertised its services and provided healthcare information on two digital screens, in the front window and in the main retail area. These provided information about various health matters which included the provision of emergency Naloxone and opening hours for upcoming public holidays. The pharmacy delivered medicines to those who couldn't visit the pharmacy in person. The pharmacy assistant was transported in a taxi to deliver these medicines to people's homes. They maintained a delivery book which was used to record deliveries. Any failed deliveries were brought back to the pharmacy. A note was left to inform people about failed delivery attempts and no medicines were left unattended.

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. And they attached coloured 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. Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these in batches twice a week. Team members prepared medicines that people took on a regular basis in advance. And supplied medicines that people took only when needed, such as creams, when people requested them, to avoid waste. 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. The pharmacy sent text messages to people when their prescription was ready for collection. This helped prevent people coming to the pharmacy before their prescription was complete.

The pharmacy supplied medicines in multi-compartment compliance packs for 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 for each week of assembly. These master sheets documented the person's current medicines and administration time. Some folders had 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. And team members provided people with patient information leaflets about their medicines each month. Shelving to store the packs was kept neat and tidy. The pharmacy also provided medication to care homes. They dispensed these medicines a week before they were needed in original packs. And provided a medicines administration record (MAR) for care home staff to record when people had taken their medicines.

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. And they always dispensed valproate in the original pack. The pharmacy supplied patient information leaflets and patient cards with every supply and had recently completed an audit of valproate patients to highlight any people the pharmacy supplied valproate to who may be at risk of becoming pregnant. The pharmacist provided appropriate advice and counselling to people receiving higher-risk medicines. And recorded interventions on people's PMR to help with future queries, such as queries raised with unusual doses.

The pharmacy used patient group directions (PGDs) to provide services such as the Pharmacy First service, emergency hormonal contraception (EHC) and unscheduled care. It kept paper records securely of supplies made using these PGDs. 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 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 and kept records of these checks. A random selection of approximately twenty medicines were checked and found to be in date. The pharmacy had disposal bins for expired and patient-returned stock.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts on receipt and kept digital records about what it had done.

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 access to the internet and a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

Team members kept clean crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy team kept clean tablet and capsule counters in the dispensary. Computers were positioned so people couldn't see confidential information and they were password protected to prevent unauthorised access. The pharmacy stored paper records in the dispensary inaccessible to the public. And it 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.