General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Edzell Pharmacy, 42 High Street, EDZELL, Angus, DD9 7TA

Pharmacy reference: 1041753

Type of pharmacy: Community

Date of inspection: 24/10/2022

Pharmacy context

This is a community pharmacy in the small rural village of Edzell, Angus. Its main activity is dispensing NHS prescriptions. 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 it supplies a range of over-the-counter medicines. 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

The pharmacy suitably identifies and manages risk. And team members follow up-to-date written procedures to help them safely carry out tasks. They keep the records they need to by law, and they safely keep people's private information. Team members record and discuss details of mistakes they make while dispensing and learn from these to reduce the risk of further mistakes.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter, hand sanitiser at the premises entrance, and face masks to offer to people who entered the pharmacy not wearing one. The pharmacy had a set of written standard operating procedures (SOPs), and it could show that team members had read and agreed to follow them. The SOPs covered tasks such as the dispensing of prescription items, selling medicines and information governance. Team members described their roles within the pharmacy and the processes they were involved in. And they accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. SOPs were reviewed by the Superintendent Pharmacist (SI) every two years.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as 'near misses.' And they recorded errors that had been identified after people received their medicines. They reviewed near misses and errors periodically to learn from them, and they introduced strategies to minimise the chances of the same error happening again. The team gave an example where the prescriber had made a change to a person's medication, but their medicines were already prepared awaiting delivery. There was a risk of the person receiving the medicines without the change being made. So the pharmacy created a comprehensive medication checklist to ensure all areas of the pharmacy were checked in case of a change of medication to reduce the risk in the future.

The pharmacy had a complaints procedure and welcomed feedback in person or in written format by email or via their website. It had current 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. It kept complete records about unlicensed medicines. The pharmacy kept controlled drug (CD) records with running balances. A random balance check of three controlled drugs matched the balance recorded in the register. Stock balances were observed to be checked on a weekly basis. 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) each night to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for secure destruction. No person-identifiable information was visible to the public. The pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. Team members were aware of the Ask for ANI (action needed immediately) scheme to help people suffering domestic abuse access a safe place.

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. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service.

Inspector's evidence

The pharmacy employed one full-time pharmacist manager, one part-time pharmacist, four part-time dispensers, one pharmacy student on a Saturday and a part-time delivery driver. On the day of inspection there were two team members working with the pharmacist, who were experienced in their roles and had been working at the pharmacy for several years. Team members had all completed accredited courses relevant to their roles. They had annual appraisals with the owner to identify any areas for development or learning needs. And they accessed and completed online training modules for continued learning. They demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. Part-time team members had some scope to work flexibly providing contingency for absence.

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. Pharmacy team members understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. And they felt comfortable making suggestions or raising concerns to the manager. The pharmacy team discussed incidents and how to reduce risks. A team member gave an example of how they had suggested a communications book for team members. They had identified a risk of important information not being passed on between part-time members of the team. The pharmacy had implemented this and found it had helped improve communication particularly around changes to people’s medication. The team had occasional informal team meetings. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is small but suitable for the services it provides. It keeps its premises clean, secure, and well maintained. And it has a suitable, sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises was small. It had a small retail area and a dispensary with space to operate safely but with limited storage space. Its 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. The staff toilet was accessed through a separate rear entrance. 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 pharmacist explained plans to build an extension to the rear of the premises to provide further space for dispensing, storage and staff facilities. Groundwork had started for these alterations.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs and computer which was clean and tidy, and the door closed which provided privacy. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. And it manages its services well to help people look after their health. The pharmacy 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 when supplying medicines to them.

Inspector's evidence

The pharmacy was accessed by means of a level entrance. It advertised some of its services and its opening hours in the main window. And it provided a delivery service. A team member prepared the day's deliveries in advance, and these were uploaded to a delivery application (app) on a dedicated mobile device for the driver. The driver used the app to plan deliveries efficiently and collect signatures from people on receipt of their medicine. Team members received up-to-date information on deliveries. This 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 baskets to separate people's medicines and prescriptions. And they used various stickers to attach 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.

Many people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy prepared these when people contacted the pharmacy to request them, usually seven days before they were needed. Team members only prepared the medicines that were requested by people 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. Team members checked regularly for any prescriptions that had not been requested. They then communicated with the GP practice to ensure the prescription remained appropriate.

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 documented information relating to the persons medicines such as any changes to medication to create a clear audit trail. 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.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving higher-risk medicines including methotrexate, lithium, and warfarin. People were supplied with written information and record books if required. Team members were aware of the guidance for

the valproate Pregnancy Prevention Programme. The pharmacy did not supply valproate to anyone in this group. The pharmacy had patient group directions (PGDs) which included unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and treatment of urinary infections. The pharmacist explained that people were often referred for these services by the GP practice. 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, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy protected pharmacy (P) medicines for 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 those inspected were 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 records about what it had done. Team members contacted people who had received medicines subject to patient level recalls. They returned 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 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.

Team members kept 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 and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.