General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Aberfoyle Pharmacy, New Building, Main Street, Aberfoyle, Stirling, Stirlingshire, FK8 3UG

**Pharmacy reference:** 9010512

**Type of pharmacy:** Community

**Date of inspection:** 07/09/2021

## Pharmacy context

This is a community pharmacy in Aberfoyle. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it offers a medicines' delivery service to vulnerable people. The pharmacy provides substance misuse services and dispenses private prescriptions. The pharmacy team members advise on minor ailments and medicines' use. And they supply a range of over-the-counter medicines and prescription only medicines via PGDs.

## 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 acts to keep members of the public and team members safe during the Covid-19 pandemic. It has policies and procedures in place and team members show they follow them. Team members discuss dispensing mistakes and make improvements to avoid the same errors happening again. The pharmacy keeps the records it needs to by law, and it keeps confidential information safe. Team members securely dispose of personal information when it is no longer required.

### Inspector's evidence

The pharmacy had carried out a documented risk assessment to manage the risks and help prevent the spread of coronavirus. The superintendent pharmacist, who had been working at the pharmacy for the past four years had identified the risks and introduced extra control measures. Notices on the entrance door reminded people visiting the pharmacy to wear a face covering as required by law. Markings on the floor of the waiting area showed people where to stand to keep a safe distance from each other. People were seen to be following the guidelines without any instruction from pharmacy team members. Hand sanitizer at the entrance was available for people visiting the pharmacy. It was also available in the dispensary and used by team members. A screen was not in use at the medicines counter, and a line of chairs in front of the medicines counter acted as a barrier between team members and members of the public.

The superintendent had defined the pharmacy's working instructions in a range of documented procedures. They had recently authorised the procedures to be used beyond their September 2020 expiry date due to time constraints caused by the coronavirus pandemic. They had annotated each of the procedures to show the extension and the authorisation. The pharmacy team was well-established and team members had recorded their signatures to show they understood and followed the procedures.

The pharmacy had systems and procedures in place to identify and manage dispensing risks. Team members signed medicine labels to show who had 'dispensed' and who had 'checked' each prescription. The pharmacist carried out the final accuracy check and discussed near-miss errors with individuals to help them improve. This also helped them to avoid the same mistakes happening again in the future. Team members reflected on their errors and what might have been the cause. The pharmacist documented them on a near-miss record form. The records provided information for the pharmacy team to identify if there were patterns and trends. It also helped them to identify when they needed extra measures to manage risks. For example, team members had separated prochlorperazine and procyclidine to manage the risk of selection errors. An incident reporting template showed a recent error.

Following an investigation, the pharmacist had identified the need for improved concentration during the dispensing process. They had not deemed it necessary to introduce extra environmental controls such as moving stock. The pharmacist trained team members to handle complaints, but they had not developed a policy or procedure for team members to refer to. A notice in the waiting area provided people with information about how to submit a complaint. Following the Aberfoyle medical practice closure during the pandemic, the local community was using the medical practice at Buchlyvie. The

pharmacy had been providing more healthcare advice and treatments and feedback about the level of service provided throughout the pandemic had been mostly positive.

The pharmacy maintained the records it needed to by law. The pharmacist in charge displayed a responsible pharmacist notice and kept the responsible pharmacist record up to date. Private prescription forms were filed in date order and electronic records were kept up to date. Valid public liability and professional indemnity insurance were in place until 8 October 2021. The pharmacy maintained its controlled drug registers and team members kept them up to date. They checked and verified controlled drug stock once a month. Team members had segregated stock awaiting destruction. They placed expired stock in bags at the bottom of the cabinet and kept them well away from other stock.

Controlled drugs that people had returned for destruction were also quarantined and kept at the bottom of the cabinet. Team members documented the returns in the controlled drug destructions register to show the stock that was being kept. The pharmacy provided a prescription delivery service. This helped vulnerable people and those that were shielding to stay at home. Drivers left items on people's doorstep and waited until they were taken safely inside. They sometimes handed items directly to people but only after sanitising their hands. They recorded the deliveries they made in the event of queries. The superintendent provided training so that team members understood how to protect people's privacy. The pharmacy did not display a notice in the waiting area to inform people about the pharmacy's data protection arrangements and how it safely processed personal information. The superintendent securely removed confidential waste for burning at home. This was carried out straight away. The superintendent provided training so that team members understood how to safeguard vulnerable people. They had not introduced a policy or procedure for team members to refer to. Team members knew their vulnerable patient groups and described their various safeguarding activities. For example, they monitored supplies of medicines in multi-compartment compliance packs and acted following failed deliveries or collections. They knew to refer to the pharmacist for advice on the best way to manage concerns. The pharmacist was registered with the protecting vulnerable groups (PVG) scheme. This also helped to protect children and vulnerable adults. A chaperone notice on the consultation room door advised people to speak to team members if they wished to be accompanied during a consultation.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

Most of the pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. They complete training as and when required. And, they learn from the pharmacist to keep their knowledge and skills up to date. Pharmacy team members speak-up and make suggestions to help improve pharmacy services.

### Inspector's evidence

A well-established, experienced team worked at the pharmacy. The dispensary was small and was sufficient in size to accommodate the pharmacist and one other team member. Two part-time trainee dispensers worked at the pharmacy and covered for each other when they were on annual leave. They also increased their hours at busy times to manage the workload. A second 'pharmacist independent prescriber' (PIP) occasionally worked at the pharmacy at the weekend. This had proven beneficial when people needed treatments that could only be provided against a prescription. Two part-time delivery drivers worked at the pharmacy. Although they had completed induction training which included the safe handling of medicines, data protection and safeguarding procedures they had not completed the necessary accredited training. The pharmacist provided the trainee dispensers with protected learning time in the workplace. The trainees also knew they were expected to complete some of the training out with the working day.

The pharmacy did not provide ongoing structured training over and above what was needed to achieve the necessary qualifications. But the pharmacist kept team members up to date with practice changes and other requirements. This had included information and procedures to keep people safe during the pandemic. The superintendent had been carrying out risk assessments in advance of introducing a private and NHS flu vaccination service. They had implemented the necessary SOPs and had planned to train the dispensers once they knew the details of the NHS service. The trainee dispenser on duty at the of the inspection knew about the valproate Pregnancy Protection Programme. They had also learned about naloxone and its use in overdose and knew to check whether people needed a supply when handing out their other medication. Team members were encouraged to suggest areas for improvement to keep the pharmacy systems safe and effective. One of the dispensers had suggested initiating the multi-compartment compliance pack dispensing process on a Friday instead of a Monday so they had more time to order stock and complete dispensing activities. This had been agreed and had made a positive impact on the workload. Team members understood the need for whistleblowing and felt empowered to raise concerns when they needed to.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean, tidy, secure and is well maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members. It has made suitable changes to its premises to help reduce the risk of spreading coronavirus.

### Inspector's evidence

This dispensary was small and team members had made the best use of the available space. One team member dispensed on a separate bench and the pharmacist checked prescriptions on a bench opposite. This allowed them to maintain the maximum distance from each other for most of the day. The trainee dispenser demonstrated the dispensing process for multi-compartment compliance packs and showed they had adequate space to dispense four packs at a time. The pharmacist observed and supervised the medicines counter from the checking bench. They could intervene and provide advice when necessary. A sound-proofed consultation room was in use and provided a confidential environment for private consultations. The pharmacy was clean and well maintained. A sink in the dispensary was available for hand washing and the preparation of medicines. Team members regularly cleaned and sanitised the pharmacy to reduce the risk of spreading infection. Lighting provided good visibility throughout and the ambient temperature provided a suitable environment from which to provide services.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people access appropriate care. The pharmacy gets its medicines from reputable sources and it stores them properly. The team carries out checks to make sure medicines are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy promoted its services and opening hours in the window at the front of the pharmacy. It had a step-free entrance and a ramp provided access for people with mobility difficulties. Several leaflets at the side of the medicines counter provided information about the pharmacy's services. There had been a significant increased demand for the NHS Pharmacy First and Pharmacy First Plus service. For example, the pharmacists had been able to provide treatments for a range of conditions such as bites and stings, ear infections and dental complaints. One of the pharmacists had recently treated someone who had been walking in the National Park after identifying a rash that indicated Lyme disease. 'Patient group directions' (PGDs) were also used to provide access to treatments. The PGD for Levonorgestrel 1500mcg was checked and was seen to be valid until August 2023. The pharmacy used dispensing baskets to keep items contained throughout the dispensing process. This managed the risk of prescription items becoming mixed-up and the cause of dispensing errors. Dispensing benches were organised and clutter-free. Team members kept the pharmacy shelves neat and tidy and a controlled drugs cabinet was organised to manage the risk of selection errors. Methadone and multi-compartment compliance packs were on the bottom shelf where there was more room. The pharmacy purchased medicines and medical devices from recognised suppliers. Team members carried out monthly expiry date checks and documented the checks on a date-checking matrix to keep track. A random check of around 12 products showed the stock to be within its expiry date. A highlighter pen had been used to highlight the date on an item that was due to expire in 2021. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. A fridge was used to keep stock at the manufacturer's recommended temperature. It was kept neat and tidy to manage the risk of selection errors. Team members monitored and recorded the fridge temperatures once a day. Records showed that the temperature had remained stable between two and eight degrees Celsius.

The pharmacy kept a record of the deliveries it made to people at home. Due to the pandemic, the delivery driver didn't ask people to sign for medicines. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. The pharmacist knew to contact prescribers on receipt of new prescriptions for people in the at-risk group. And they kept supplies of Patient Information Leaflets to be issued with supplies. The pharmacy supplied medicines in multi-compartment compliance packs for people in their own homes. The superintendent had not defined the assembly and dispensing process in a documented procedure for team members to refer to. Team members cleared the dispensing bench before they started the assembly process due to restricted space. The pharmacist processed the prescriptions and produced 'backing sheets' which listed each person's medication and dose times. Team members checked prescriptions against people's medication records before they started dispensing. They used a template to record prescription changes. This provided an audit trail for any queries they may receive.

Team members sometimes annotated descriptions of medicines on the packs, but not always. They provided patient information leaflets with the first pack of the 4-pack cycle. The superintendent had produced a procedure that defined the process for handling drug alerts. Team members processed drug alerts straight away. They knew to check for affected stock so that it could be removed and quarantined. A recent drug alert for Aprovel in August 2021 showed it had been checked with no affected stock found.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy’s equipment is clean and well-maintained. It uses equipment appropriately to protect people's confidentiality. It takes precautions so that people can safely use its facilities when accessing its services during a pandemic.

### Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It used crown-stamped measuring equipment. Separate measures were used for methadone. The pharmacy stored prescriptions for collection out of view of the waiting area. It arranged computer screens so they could only be seen by the pharmacy team members. The pharmacy had a cordless phone, so that team members could have conversations with people in private. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

## 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. |