General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gardner Drive Pharmacy, 62 & 68 Gardner Drive, Aberdeen, Aberdeenshire, AB12 5SD

Pharmacy reference: 9011416

Type of pharmacy: Community

Date of inspection: 02/10/2023

Pharmacy context

This is a community pharmacy within a small parade of neighbourhood shops in Aberdeen. 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. It supplies medicines to people living in care homes. The pharmacy offers a medicines delivery service and it provides substance misuse services. The pharmacy team advises on minor ailments and medicines' use.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	The pharmacy does not always keep consultation records for medicines prescribed by the pharmacist. This includes documentation of the consultation with the person, examination records, and any follow up or monitoring that needs to be done.
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 not all met**

Summary findings

The pharmacy does not always keep the records it should when the pharmacist provides a service prescribing medicines for people. This means important information may not always be available to ensure the pharmacy supplies its medicines safely. Pharmacy team members follow safe working practices. And they suitably manage dispensing risks to keep services safe. Team members recognise and appropriately respond to safeguarding concerns. They protect people's private information. Team members make records of mistakes and they make changes to help reduce the risk of future similar mistakes.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs), and team members had read and agreed to follow them. The SOPs covered tasks such as the dispensing of prescriptions and selling over-the-counter medicines. SOPs had been reviewed by all team members within the last year. Team members described their roles within the pharmacy and the processes they were involved in relating to these roles. They accurately explained which activities could not be undertaken in the absence of the responsible pharmacist (RP). The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members team described the process for branch closure when there was no responsible pharmacist available.

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 all near misses and errors regularly to learn from them and they introduced strategies to minimise the chances of the same error happening again. This included highlighting mistakes to the team member involved to learn from, and they rearranged stock on the shelves to avoid selection errors. The pharmacy had a complaints procedure and welcomed feedback. They asked people to complete anonymised questionnaires about their services and previous results were all positive. The pharmacy trained its team members to manage complaints. And they knew to provide the contact details for the SI’s office if people wished to complain.

The pharmacy had current indemnity insurance. The RP notice was updated as the inspection began to reflect the correct details of the RP on duty. And it had an accurate RP record. From the records seen, it had accurate private prescription records including records about emergency supplies and veterinary prescriptions. The pharmacy kept digital 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 monthly basis. The pharmacy had a CD destruction register and recorded CDs that people had returned to the pharmacy. The pharmacy backed up electronic patient medication records (PMR) to avoid data being lost.

The pharmacy supplied people with medicines to treat minor ailments via the NHS Pharmacy First and Pharmacy First Plus services. The pharmacist was a qualified pharmacist independent prescriber (PIP) and was supported by other prescribers within the group of pharmacies. The PIP explained that they treated a variety of conditions under Pharmacy First Plus, including conditions affecting the skin and minor infections of the ears and chest. PIPs managed the risk as they worked to an agreed formulary that listed what medication could be prescribed, supporting information for prescribers, and when

referral to people's GP would be appropriate. The pharmacy notified people's GP, usually by email, if they were prescribed a medicine by the PIP. The PIP demonstrated the template for electronically recording prescribing consultations. But there were no consultation records completed for prescriptions that had been issued for a number of months. The only records referring to these prescriptions were the details of people's name, medication supplied, and dosage instructions that had been supplied to GPs. Consultation records document the prescriber's examination findings, reasons for prescribing decision, the treatment prescribed and any follow-up or monitoring that needs to be done either by the pharmacist prescriber or general practitioner. A lack of these records make it more difficult for a future prescriber to refer to this decision and allow continuity of care. And make it difficult to answer any queries from other healthcare professionals. The PIP agreed to complete these again with immediate effect when this was highlighted.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for shredding. 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. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. They knew how to raise a concern locally and had access to contact details.

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. And 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, two full-time dispensers, three part-time dispensers, and a part-time delivery driver. The pharmacy displayed their certificates of qualification. On the day of inspection there were two team members working with the pharmacist manager. Team members were seen to be managing the workload. They explained that they had recently started sending prescriptions for multi-compartment compliance packs to another pharmacy within the same company for automated dispensing. This had significantly reduced workload pressure. Team members spoken to during the inspection were experienced in their roles and had been working at the pharmacy for several years. They demonstrated a good rapport with many people who visited the pharmacy. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy did not plan learning time during the working day for team members to undertake regular training and development. But they did provide ad-hoc training when needed, such as when a new service was introduced. Team members had appraisals with the pharmacy manager to identify their learning needs. They 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. And they dealt appropriately with such requests.

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. They felt able to make suggestions and raise concerns to the manager. The team had informal daily meetings to plan the day’s workload appropriately. The pharmacy had a whistleblowing policy that team members were aware of.

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

The pharmacy had been extended since the last inspection. It incorporated a retail area, large 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. Its overall appearance was professional. The pharmacy had clearly defined areas for dispensing, a separate area for preparing medication for care homes, and the RP used a separate bench to complete their final checks of prescriptions.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs and a sink which was clean and tidy, and the door closed which provided privacy. And it provided a clinical environment for the administration of vaccinations and other services. The pharmacy also had a separate area for specialist services such as substance misuse supervision. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services easily accessible for 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.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance. The pharmacy advertised some of its services and its opening hours in the main window. Team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to 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. A team member prepared a list of the day's deliveries and kept this in the dispensary. This ensured that team members were aware of the day's scheduled deliveries. This was useful if people called the pharmacy asking about their expected delivery.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy prepared these weekly in advance of when people were due to collect them. 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 supplied medicines in multi-compartment compliance packs to people who needed extra support with their medicines. Pharmacy team members managed the preparation and record-keeping for these on a four-weekly cycle. The pharmacy sent most of these to another pharmacy within the company to use an automated dispensing system. Team members worked several days in advance of supply to allow for issues such as delays with prescriptions and faults with the automated system. The pharmacist clinically assessed prescriptions and determined if the medication was suitable for the automated system before a copy of the prescription was electronically sent to other pharmacy for dispensing. Prescriptions with more than 14 medicines, CDs and medicines that should remain in the original packaging were not added to the automated system. 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. The pharmacist carried out a further accuracy check on receipt of the packs in the pharmacy. Shelving to store the packs was kept neat and tidy. The pharmacy also provided pharmaceutical services to care homes. Medication was prepared in a monthly cycle and supplied with administration charts for use by care home staff. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were stored in individually named baskets on labelled shelves.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving higher-risk medicines including methotrexate and warfarin. Team members were aware of the valproate Pregnancy Prevention Programme. The pharmacy did not supply valproate to anyone in this group. The pharmacy had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. 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 PIPs supporting the Pharmacy First Plus service worked to a national service specification and prescribed to a local formulary. They used NHS prescriptions with unique prescriber numbers so their prescribing activity could be reviewed and audited. Local GP teams were aware of the service and signposted people to the pharmacy.

The pharmacy provided injectable treatment to some people requiring treatment for substance misuse. The pharmacist had attended local specialist training for the service. They administered the injection under agreement with the local addiction team and monitored people after the injection. They kept records of administration and worked collaboratively with the local addiction team to ensure that all parties were aware when treatment had been administered.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging 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 three separate pharmaceutical fridges. Team members monitored minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. But some records were incomplete as they had not documented records for each individual fridge. Temperatures were seen to be within accepted limits during the inspection. The pharmacist gave assurances that records would be maintained following the inspection. Team members regularly checked expiry dates of medicines but did not record the date of when these checks were carried out. A random check of twenty medicines inspected found one to be out of date showing the current process was not completely robust. 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.

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.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a blood pressure meter which was replaced as per the manufacturer's guidance. 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.

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 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.