General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Prestonlinks Pharmacy, Unit 2, Prestonlinks Shopping Centre, 65c High Street, PRESTONPANS, East Lothian, EH32 9AF

Pharmacy reference: 1042038

Type of pharmacy: Community

Date of inspection: 02/12/2024

Pharmacy context

This is a pharmacy on a high street in the seaside village of Prestonpans in Lothian. Its main activities are dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs to help them take their medicines properly. It delivers medicines to some people in their homes. And it provides NHS services such as NHS Pharmacy First.

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	1.1	Standard not met	Pharmacy team members do not have complete set of written procedures for the activities they perform. And not all team members have read the written procedures available to them.
		1.2	Standard not met	The pharmacy does not have a robust process for team members to learn from mistakes. And not all team members know how to record mistakes made when dispensing. They do not complete reviews of mistakes or demonstrate sufficient learning and changes to the way they work following mistakes. This was similar at the last inspection.
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 not all met	4.3	Standard not met	The pharmacy does not store all its medicines as it should, including some of its higher risk medicines. This was seen at previous the previous inspection and so improvements have not been maintained.
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 have all the written procedures it needs to manage risk and help team members provide services safely. And not all team members know how to record mistakes made during the dispensing process. They do not always review these mistakes to help learn from them. Team members mostly keep the records required by law. They understand how to keep people's private information secure. And they know how to respond to concerns for the welfare of vulnerable people using the pharmacy's services.

Inspector's evidence

The pharmacy had two standard operating procedures (SOPs) that team members were able to show on the day of the inspection. These were about dispensing and handing out prescriptions. SOPs about the responsible pharmacist (RP), controlled drug management (CD), and managing errors were not seen. Team members struggled to locate the SOPs that they could refer to. Team members found a folder of SOPs that were provided by a third-party provider but they had not been annotated to indicate they had been authorised for use by the superintendent pharmacist (SI) or signed by team members to indicate they had been read and understood. The two SOPs seen had been signed by most team members in November 2023. A new dispenser had been employed for several months but had not yet read any of the SOPs. And there was no plan in place for the dispenser to read the SOPs. Team members present during the inspection were able to describe some of the procedures for their roles. For example, the recently employed dispenser knew how to dispense as they were a qualified dispenser and worked alongside other team members. But team members were not able to demonstrate they knew all the procedures for their roles, including how to complete date checking of medicinal stock.

The pharmacy had recorded some mistakes identified and rectified during the dispensing process known as near misses. A paper-based record was found during the inspection which showed that five near misses had been recorded between June and July 2024. No further records of recent near misses were seen. There were other paper-based historical near miss records found separately in the dispensary and so not all records were kept together, which caused confusion. The records from June and July 2024 did not capture all the details of the near misses, such as the medicine involved or why it had happened. This means that team members may miss opportunities to learn from the mistakes. Team members present during the inspection were unable to demonstrate the process for how near miss records were made as this was the responsibility of a dispenser who was not present during the inspection. The pharmacy did not have a formal process for reviewing mistakes made to identify trends. Some team members had identified common errors that they had personally made. One example involved two different forms of an inhaler and the dispenser had learnt the inhalers came in different pack sizes, so understanding this could help prevent future selection errors. Another team member discussed ensuring dispensing was completed from prescriptions and not dispensing labels to minimise errors. They indicated that changes would be made to separate medicines involved in near misses where they were kept, but the two forms of inhalers identified by a dispenser were still kept next to each other in a drawer. The pharmacy recorded details of errors identified after a person had received their medicines, known as dispensing incidents. An example of a dispensing incident recorded in July 2024 was seen. Team members confirmed there had been a dispensing incident made the week before the inspection, which was still to be recorded. Although the pharmacist had not yet recorded details about the incident, they had discussed with team members potential reasons for the incident occurring and had taken steps to help prevent this type of error from occurring again. This included

directing team members to use an appropriately sized basket to keep prescriptions and medicines together. The pharmacy had a complaints policy and the team aimed to resolve any complaints or concerns informally. And if they were unable to resolve the complaint, they would escalate to the manager or SI.

The pharmacy had current professional indemnity insurance. Team members were aware of the tasks that could and could not be carried out in the absence of the RP. The RP record was displayed prominently in the retail area and reflected the correct details of the pharmacist on duty. The RP record was mostly completed correctly with a few omissions of the RP on duty over the past three months. This was an improvement since the previous inspection. The pharmacy kept electronic records of the receipt and supply of its CDs and maintained running balances. And the pharmacist had undertaken significant work since the previous inspection to ensure the CD records were now accurate. The pharmacist completed checks of the stock held against the CD register running balance weekly which was an improvement since the last inspection. Details of medicines returned by people who no longer needed them were recorded. The pharmacy kept certificates of conformity for unlicensed medicines known as “specials”. Team members recorded the details of who the medicine was supplied to which provided an audit trail. The pharmacy kept complete records of the supply of medicines made against private prescriptions and kept associated prescriptions.

Although they had received no formal training, team members were aware of their responsibility to keep people’s private information secure. They separated confidential waste for destruction. Team members explained that their usual process was to shred the confidential waste on site, but that their shredder had broken. This had been reported to the owner and team members were awaiting a new shredder. There was no build up of confidential waste seen. Team members were also aware of their responsibility to safeguard vulnerable adults and children. They referred to the dispenser manager or the pharmacist in the first instance. And they gave an example of liaising with another healthcare professional when they had concerns about a person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has sufficient qualified team members to manage its workload and provide services safely. Team members work well together and communicate effectively with each other. And they suitably support people with their healthcare needs. They receive some ad hoc training but as the pharmacy doesn't provide regular structured training, team members may miss opportunities to further develop their knowledge and skills.

Inspector's evidence

The RP at the time of the inspection was a newly employed resident pharmacist. They were supported by two dispensers. The pharmacy had a medicines counter assistant and four further dispensers, one of whom was the manager, who were not present during the inspection. And a delivery driver worked part-time to deliver medicines to people in their homes. Team members were seen to be managing the workload and were generally up to date with routine dispensing and were working in advance for the dispensing of multi-compartment compliance packs. And they were seen assisting each other with queries. Annual leave was planned in advance for team members by the dispenser manager and the SI. And pharmacist's days off were covered by locum pharmacists. Part-time team members and team members from a nearby pharmacy owned by the same company supported periods of absence where required.

The pharmacy did not generally provide ongoing learning time during the working day for team members to undertake regular training and development, which was seen at the previous inspection. The pharmacist had provided some training about CDs to team members. And they had had discussions with them about the NHS Pharmacy First service so they were able to assist people accordingly. Team members asked appropriate questions when supplying over-the-counter medicines. They were vigilant to repeated requests for medicines liable to misuse, for example codeine containing medicines. The pharmacist had supportive conversations with people who were repeatedly requesting such medicines. The pharmacy did not set its team members targets.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the pharmacy premises are small but suitable for the services it provides. And they are secure and clean. It has a suitable soundproofed room where people can receive services and have private conversations with team members.

Inspector's evidence

The pharmacy had a small dispensary and a slightly larger retail area. There was a small back shop area that included limited storage space and staff facilities. There were designated areas in the dispensary for dispensing and for the RP to complete final checks of the prescriptions. There was limited space for storing medicines and completed prescriptions, and while shelves were relatively neat and tidy, some multi-compartment compliance packs were stored on the floor, which presented a trip hazard for team members and may not be hygienic. And there were some bags in front of the rear fire exit, which although this meant the fire exit was partially blocked, they could be removed by team members in an emergency. The premises were generally clean. There was a sink in the dispensary which provided hot and cold water for hand washing. Toilet facilities were clean and had hand washing facilities.

The pharmacy's medicines counter provided a barrier to help prevent unauthorised access to the dispensary. And people in the retail area were not able to see the activities that took place in the dispensary. The RP's checking bench was situated so they were comfortably able to supervise the medicines counter and dispensary. The pharmacy had a consultation room with a desk, chairs and sink. And there was a hatch for team members to supervise the administration of medicines associated with the substance misuse service. Lighting provided good visibility throughout the pharmacy and the temperature was comfortable.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy receives its medicines from recognised wholesalers, but it does not always store medicines as it should, including some of its higher-risk medicines. And it does not always carry out regular checks to ensure they remain fit for supply. Overall, the pharmacy provides its services safely and effectively. And it makes them accessible to people. Team members provide people with the necessary information to take their medicines safely and effectively.

Inspector's evidence

The pharmacy had level access from the street which provided access to those with limited mobility using wheelchairs or with prams. Team members provided large print labels to those with visual difficulties. The pharmacy advertised some of its services and opening hours in the main window. And it had a range of healthcare leaflets on display in the retail area and in the consultation room for people to read or take away.

Team members used baskets to keep people's prescriptions and medicines together and reduce the risk of errors. They used stickers to highlight the inclusion of a CD, fridge line, or if referral to the pharmacist was necessary upon handout. Team members highlighted the inclusion of a CD on multi-compartment compliance packs using stickers, which had been introduced after the previous inspection. They signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members had an awareness of the pregnancy prevention programme (PPP) for people who were prescribed valproate and knew not to cover the warning information on manufacturers packs, to help people take their medicines safely. Team members provided people with a note of medication owed if they couldn't supply the full quantity of medicine prescribed. And they gave examples of signposting people to other pharmacies to obtain the medicine if none could be supplied.

The pharmacy provided a delivery service, taking medicines to people in their homes. Medicines that required cold storage were held in a specific fridge in the pharmacy. And fridge items were highlighted on the delivery sheet next to a person's name and address label, so the driver was aware there were fridge items to be delivered. The driver asked people to sign to confirm receipt of their CDs. Any medicines that were unable to be delivered were returned to the pharmacy. The pharmacy supervised the administration of medicines for some people. It managed the service by preparing the doses ahead of when people came to collect them.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. And they were ahead with workload leading up to the busy Christmas period. The pharmacy had master backing sheets for each person, with a record of the medicines taken and the administration times. A copy of the backing sheet was attached to each of the packs supplied to people. The GP informed the pharmacy of changes to people's medication and the pharmacy record was updated. Team members provided people with descriptions of the medicines in the packs so they could be easily identified. And they provided people with patient information leaflets once a month, so they had the necessary information to take their medicines safely.

The pharmacy used a 24-hour collection point machine and team members sent text messages to let

people know their medication was ready for collection. People collected their prescriptions from the machine using a unique PIN code. This was at their own convenience even when the pharmacy was closed. The pharmacy excluded some medications such as CDs and items that required refrigeration. And team members regularly checked the machine for uncollected items which they removed and contacted people to let them know.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only medicines were stored behind the medicines counter which helped ensure the sales were supervised by the pharmacist. The pharmacy did not store all medicines as it should including some of its higher risk medicines. Team members were unsure of the process for date checking the dispensary stock. However, some checks of the dates of medicinal stock were completed by a locum pharmacist in September 2024. And team members checked the expiry dates of medicines during the dispensing and checking process which reduced the risk of an out-of-date medicine being supplied. They highlighted liquid medicines with a shortened expiry on opening with the date of opening. An example of this was seen, but the medicine had expired and was removed during the inspection. A random selection of 15 medicines found none past their expiry date. The pharmacy stored medicines requiring cold storage in two fridges in the pharmacy, one of which displayed a sign indicating that it was meant to store food items only. Team members did not record the temperature of the fridges daily. Records showed eight records had been completed in November 2024 and six in October 2024 with the last recorded showing the fridges were operating within the required two and eight degrees Celsius. Where team members observed a high maximum temperature, some records of the action taken to resolve this were made. The maximum temperature of the fridge used for food items was showing as 9.7 degrees Celsius on the day of the inspection. The pharmacist explained this may be due to the fridge door being open too long at points. The pharmacy received notifications about drug alerts and recalls via emails. But they did not have a specific process to follow to show how they were actioned. Some of the alerts were marked on the computer as read to show they had actioned the alerts and others were not. A discussion with the pharmacist about having a procedure to action alerts was had.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had electronic reference resources including the British National Formulary (BNF) and BNF for children (BNFc) so its team members had up to date information to refer to about medicines. And they had access to internet services.

The pharmacy had a range of clean crown marked measuring cylinders which were marked to identify which were for water and which were for liquid medicines. It had a 24-hour collection point with engineer support available via telephone. The pharmacy stored medicines in a way which prevented members of the public from seeing people's private information. Computer screens were positioned within the dispensary so that unauthorised people couldn't see any confidential information. The pharmacy had cordless telephones for conversations to be taken in a private area.

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.