General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M & D Green Dispensing Chemist Ltd,

Stenhousemuir Pharmacy, 13 King Street, STENHOUSEMUIR, Stirlingshire, FK5 4HD

Pharmacy reference: 1043035

Type of pharmacy: Community

Date of inspection: 12/07/2024

Pharmacy context

This is a community pharmacy in Stenhousemuir. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via patient group directions (PGDs).

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

The pharmacy team members mostly work to professional standards to help keep services safe and effective. They discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes and reduce the risk of errors. The pharmacy keeps the records it needs to by law, and it protects confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The pharmacy defined its working practices in a range of relevant standard operating procedures (SOPs) and they were readily available for team members to read whenever they needed to. The superintendent pharmacist (SI) had approved and issued a new set of pharmacy SOPs in November 2023 and team members had read and signed them to confirm their understanding and ongoing compliance. The pharmacy employed an accuracy checking pharmacy technician (ACPT) and a documented SOP defined the final accuracy checking procedure. But they did not accurately follow the procedure, which required pharmacists to use a checking stamp and annotate the bottom left-hand corner of prescriptions they deemed suitable for the ACPT to accuracy check. Pharmacists annotated the supplementary pharmacy records that team members used to help them dispense multi-compartment compliance packs but not the original prescription. This meant the pharmacy was not always able to provide assurances that it was managing all the dispensing risks it had identified.

A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This helped the pharmacists and the ACPT identify and help team members learn from their dispensing mistakes. This included monitoring mistakes identified before they reached people, known as near miss errors. Team members recorded their own errors to help them reflect on the cause of the error and to learn from it. And the trainee pharmacist carried out regular documented reviews which they discussed with the pharmacy team to agree actions and safety improvements to manage dispensing risks. This included separating medicines with similar names, such as colchicine and cyclizine and the different strengths of omeprazole to manage selection risks. Team members refreshed their knowledge of the pharmacy's procedures through the reading of SOPs. And they re-organised the dispensary shelves when they became congested and untidy. The company had introduced a self-audit tool following a recent discussion at a regular meeting the SI chaired, and all the pharmacist managers attended. This had been informed by recent findings in GPhC inspection reports. The tool helped team members to identify non-compliance with the company's governance arrangements. For example, making sure that patient information leaflets (PILs) were always provided alongside medication. A notice in the waiting area informed people of the pharmacy's complaints handling procedure. Team members knew how to manage complaints and knew to escalate dispensing mistakes that people reported after they left the pharmacy. The pharmacist discussed the incidents with team members, so they learned about the risks in the pharmacy and how to manage them to keep dispensing safe.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area and the RP record was up to date. Team members maintained controlled drug (CD) registers and they checked the balance recorded in the register matched the physical stock, once a month. The pharmacy kept records of CDs that people returned for

disposal which contained signatures to provide an audit trail when destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed and they kept records of supplies of unlicensed medicines and private prescriptions that were up to date. A notice in the waiting area provided assurance that the pharmacy protected people's confidential information and the pharmacy trained its team members to safeguard sensitive information. This included the use of a shredder to dispose of confidential waste safely and securely. The pharmacy trained its team members to identify vulnerable adults and children and the pharmacy's policy was being displayed on the dispensary wall for ease of access. They knew to escalate safeguarding concerns and to discuss them with the pharmacist to protect people. For example, when some people did not collect their medication on time, and when the driver was unable to complete deliveries that had been previously arranged.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy supports team members to learn and develop.

Inspector's evidence

The following team members were in post; two full-time pharmacists, one part-time ACPT, two full-time dispensers, three part-time dispensers, two full-time trainee dispensers, two full-time trainee medicines counter assistants (MCAs), two part-time students that were in the process of completing dispenser training and one trainee pharmacist. The pharmacy had contingency arrangements in place to manage team members leave and one of the part-time dispensers and the students worked extra to maintain adequate staffing levels. Two regular pharmacists worked at the pharmacy and the company provided backfill when they were on leave. For example, one of the pharmacists was undergoing qualification training to become an independent prescriber and locum cover had been provided. The pharmacy regularly reviewed its staffing levels and skill mix arrangements and made improvements when there were shortfalls. The pharmacy recruited new team members to replace individuals that left. And the pharmacists and the other team members supported them whilst they underwent induction which included reading the pharmacy SOPs to confirm they understood and would adhere to them. The company enrolled new team members onto qualification training within the necessary timescales and the pharmacy provided protected learning time in the workplace. This ensured they were supported in their studies and made satisfactory progress with training. One of the pharmacists had been coaching the trainee MCAs on a one-to-one basis to help them ask people the relevant questions. And to gather the necessary information to help them appropriately refer people to the pharmacist.

The pharmacists ensured team members kept up to date in their roles and responsibilities. And they arranged training, so they were competent to provide the services the pharmacy offered. For example, one of the pharmacists and the ACPT had completed training to provide an ear wax removal service. And team members had recently attended an event to learn about a new mobile Application to help people order their prescriptions for repeat medication. They also had attended training to ensure they followed the pharmacy's procedures to dispense prescriptions safely and effectively for people living in care homes. Team members discussed near miss errors to identify learnings and to make improvements to keep dispensing safe and effective. They had also discussed legislative changes and team members knew only to dispense full packs of valproate-containing medication unless in exceptional circumstances. The pharmacists delegated responsibility to senior team members. For example, one of the dispensers managed the dispensing of multi-compartment compliance packs. They also ensured that two dispensers maintained their knowledge and skills to keep up to date so they could provide backfill when required.

The pharmacist encouraged team members to provide feedback and suggest service improvements. The team had recently suggested changes to the way they processed prescriptions for multi-compartment compliance packs (MDS). And they checked the new prescriptions against the pharmacy's supplementary records at the beginning of the dispensing process. This helped them to quickly resolve queries to avoid delays with people's medication. The pharmacy trained team members so they

understood their obligations to raise whistleblowing concerns. This ensured they knew when to refer concerns to the pharmacist or another team member.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has adequate facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy was in modern purpose-built premises. Team members managed the available workspace well to ensure dispensing procedures were conducted safely and effectively. They had designated workstations depending on the various tasks they conducted. This included separate areas for the necessary checks that were carried out by pharmacists and the ACPT. A rear room was used to assemble and label multi-compartment compliance packs and prescriptions for care homes. This provided sufficient space for the prescriptions and the relevant documentation to keep dispensing safe. The pharmacists had good visibility of the medicines counter and could intervene when necessary.

The pharmacy had a well-equipped consultation room. It provided an environment for people to speak freely with the pharmacist and other team members during private consultations. There was a clean, well-maintained sink in the dispensary that was used for medicines preparation. And team members cleaned and sanitised all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout. And the ambient temperature provided a suitable environment to store medicines and to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services safely. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team conducts checks to make sure medicines are in good condition and suitable to supply. And they identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy provided a ramped entrance for people with mobility difficulties. And it displayed its opening hours and some of its services in the main window. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were fit for purpose. These included checks of expiry dates which they documented to show when checks were next due. A random check of dispensary stock found no out-of-date medicines. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. And team members read and recorded the temperature every day to show that fridges remained within the accepted range of between two and eight degrees Celsius. The fridge was organised with items safely segregated which helped team members manage the risk of selection errors. Team members used two secure cabinets for some of its items and medicines were organised with segregated items awaiting destruction. The pharmacy received drug alerts and recall notifications. Team members checked the notifications and acted on them when necessary. They kept audit trails to confirm they had conducted the necessary checks which included removing affected items and isolating them from stock. For example, they showed they had acted on an alert for itraconazole in July 2024. The pharmacy had medical waste bins and denaturing kits available to support the team in managing pharmaceutical waste.

Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances. The pharmacists had carried out individual risk assessments for people who received valproate in a multi-compartment compliance pack to confirm it was appropriate to continue to do so. The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. The pharmacy dispensed a considerable number of multi-compartment compliance packs. A lead dispenser managed the ordering and receipt of the prescriptions to ensure people received their medication when it was due. Team members dispensed the packs over a four-week period, and they used supplementary pharmacy records to document the person's current medicines and administration times. This allowed them to carry out checks and identify any changes that they queried with the GP surgery. Team members supplied patient information leaflets (PILs) with the first pack of the four-week cycle. And they provided descriptions of individual medicines to help identify them in their packs. The pharmacy kept records to show the packs that people collected and those the pharmacy had delivered. This provided confirmation that people had received their medicines and prompted team members to act when there were failed collections or deliveries.

Two care homes establishments sent prescriptions to the pharmacy on a regular basis for dispensing. The pharmacy dispensed the prescriptions according to an agreed schedule, so people received their medication when it was due. Team members checked the prescriptions against records of previous supplies, and they spoke to care home team members to confirm any changes. They provided medicine administration record (MAR) charts to help care home team members with the administration of medicines.

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 access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used a separate measure for substance misuse medicines. They had highlighted the measure, so it was used exclusively for this purpose. The pharmacy stored prescriptions for collection out of view of the public waiting area and it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could conduct conversations in private if needed, using portable telephone handsets.

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.