General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Larbert Pharmacy, 94-96 Main Street, LARBERT, Stirlingshire, FK5 3AS

Pharmacy reference: 1091730

Type of pharmacy: Community

Date of inspection: 29/09/2023

Pharmacy context

This is a community pharmacy in Larbert. 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 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	The pharmacy does not keep its policies and procedures up to date, and there is evidence that team members do not follow them.
		1.2	Standard not met	The pharmacy does not routinely record near miss errors and dispensing mistakes. And there are no arrangements in place to learn from things that go wrong.
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	4.2	Standard not met	The arrangements at the pharmacy do not provide the necessary assurances that all of its prescriptions are safely supplied.
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 keep its policies and procedures up to date. And there is evidence to show that team members do not always follow them. The pharmacy does not keep records of near misses or dispensing mistakes. And it does not take the opportunity to monitor and provide assurance that services are safe. Team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's confidential information and keep the records they need to by law.

Inspector's evidence

The pharmacy had appointed a new responsible pharmacist (RP) in August 2023. They knew the pharmacy's standard operating procedures (SOPs) had not been reviewed since 2020 and they had been informed that a pharmacist at another branch was reviewing and updating them. The RP had been in communication with the superintendent pharmacist (SI) to discuss relevant matters. And the owner visited the pharmacy on a weekly basis to confirm the pharmacy was operating effectively. The RP had identified some service risks and had introduced some new safety measures to manage them. There was evidence to show that some team members had read and signed the SOPs. But the signature audit trail showed some team members who no longer worked at the pharmacy and some who had taken up new posts. There was evidence to show that team members did not always follow SOPs. This included the procedure for conducting final accuracy checks on prescriptions. The RP relied on dispensers to accuracy check new prescriptions for multi-compartment compliance packs against the previous supply recorded on supplementary records. And when they identified changes, they passed the prescription to the RP to conduct a clinical check who annotated the person's record. This provided the necessary authorisation for the accuracy checking pharmacy technician (ACPT) to conduct a final accuracy check. Team members dispensed some prescriptions without the RP seeing them. And the ACPT checked prescriptions in the absence of a relevant clinical check and annotation. There was evidence to show team members did not follow the near miss record keeping procedure and they did not document near miss errors as required to do so. This meant they missed opportunities to identify patterns and trends and to learn and mitigate risks in the pharmacy.

Team members signed medicine labels to show who had dispensed and who had checked prescriptions. This provided the RP and the ACPT with the opportunity to help individuals learn from their dispensing mistakes. The RP had ongoing discussions with team members about changes or improvements. For example, reminding them to record near miss errors and to take greater care with look alike and sound alike (LASA) medications. They had discussed hydralazine and hydroxyzine medications due to an increase in the number of prescriptions and selection errors. Team members knew how to manage complaints. And they knew to refer dispensing mistakes that people reported after they left the pharmacy. The pharmacist described a recent incident when the wrong quantity had been supplied. But the relevant RP or the other team members had not documented the incident on the relevant electronic form which was designed to include information about the root cause and any safety improvements. The RP could not confirm whether dispensing mistakes were reviewed by the SI or the owner.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 29 April 2024. The pharmacist displayed a responsible pharmacist (RP) notice. But this was not visible from the waiting area. The RP

notice showed the name and registration details of the pharmacist in charge. The RP record showed the time the pharmacist assumed their duties, but it did not always show the time their duties ended. The RP maintained the controlled drug (CD) registers and kept them up to date. And they had authorised only experienced team members to check and verify the balances once a week. People returned CDs they no longer needed for safe disposal. And team members used a CD destruction register to document items which the RP signed to confirm destructions had taken place. The RP had introduced an extra accuracy check for CDs. And team members knew to obtain an accuracy check from the RP before they handed them out. For example, before they handed prescriptions to the driver for delivery. Team members filed prescriptions so they could easily retrieve them if needed. And they kept records of supplies against private prescriptions and supplies of unlicensed medicines ('specials') that were up to date. Team members understood data protection requirements and knew how to protect people's privacy. For example, they used a shredder to dispose of confidential waste. Team members knew how to manage safeguarding concerns effectively and the RP confirmed that team members referred individuals when they had cause for concern. A chaperone notice advised people they could choose to be accompanied when they spoke to team members in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members mostly have the necessary qualifications and skills for their roles and the services they provide. They work together to manage the workload. Team members sometimes discuss improvements to keep services safe. But there is evidence to show they do not aways apply the learning in practice.

Inspector's evidence

The pharmacy's prescription workload had increased and there had been staffing changes with some team members leaving and new team members appointed to replace them. The pharmacy had been operating with different locum pharmacists. And a new RP had been appointed in August 2023. They had introduced some safety measures and briefed the pharmacy team so they could apply the changes in practice. This included the need to record near miss errors to help them learn and improve. But there was evidence to show that this had not been implemented. Most team members were long-serving and experienced in their roles. This included one full-time pharmacist, one full-time pharmacy technician, one full-time dispenser (supervisor), four full-time dispensers, three part-time dispensers, one full-time medicines counter assistant (MCA), one part-time MCAs, two trainee MCAs. Four part-time delivery drivers worked at the pharmacy. But they had not been enrolled on the necessary qualification training for new delivery drivers.

An ACPT worked at the pharmacy and supported the RP by conducting final accuracy checks for multi-compartment compliance packs. The ACPT was about to leave their post and an experienced dispenser had been selected to undergo an accuracy in checking qualification. The RP had discussed staffing with the owner, and they had agreed to provide a second pharmacist in the interim to manage the risk of staffing pressures. Senior dispensers took responsibility for certain complex tasks, for example multi-compartment compliance pack dispensing and the dispensing of some other high-risk medicines.

The pharmacy managed annual leave requests with only one MCA and one dispenser authorised to take leave at the one time. This managed the risk of staffing pressure and helped with service continuity. A trainee MCA worked every Saturday, and a rota was in place so that weekday staff provided Saturday cover. The RP briefed the pharmacy team about changes to new and existing services. This included the recent introduction of the NHS seasonal flu and Covid-19 vaccination service. They had also reminded team members to review the formulary for the NHS pharmacy first service, so they were up to date. Team members had started to rearrange to medicines counter, so that formulary items were easy to identify and select. The RP had discussed pharmacist independent prescriber (PIP) training and the owner had agreed to support them to undertake the course in 2024.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of its services. And it effectively manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The premises provided a large, modern, purpose-built environment from which to safely provide services. A sound-proofed consultation room was available for use. And it provided a confidential environment for people to speak freely with the pharmacist and other team members during private consultations. It also provided a clinical environment for the provision of vaccination services. A separate booth provided a private area for the supervised consumption of some medicines. Team members regularly cleaned and sanitised the consultation room and the pharmacy. This ensured they remained hygienic for its services. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate room provided an area for team members to have comfort breaks.

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

Summary findings

The pharmacy provides services which are easily accessible. But it does not aways provide its services in accordance with the safe working practices. This means there is a lack of assurance that multi-compartment compliance pack dispensing is safely provided. 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. But it cannot show it has arrangements to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

A step-free entrance provided access to the pharmacy which helped people with mobility difficulties. And it provided some patient information leaflets for people to self-select. The pharmacy purchased medicines and medical devices from recognised suppliers, and it had a systematic approach for date checking which managed the risk of supplying short-dated stock in error. Sampling showed that stock was well within its expiry date. The pharmacy used three fridges to keep medicines at the manufacturers' recommended temperature. The pharmacy kept an audit trail to show the fridge had remained with the accepted range of between two and eight degrees Celsius. The fridges were organised with items safely segregated. This helped them manage the risk of selection errors.

Team members used four secure CD cabinets for some of its items. Medicines were well-organised, and a separate cabinet was used for multi-compartment compliance packs. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. Team members remembered receiving notifications of drug alerts and recalls which they said they had prioritised. But they could not evidence they always checked for affected stock. They produced a drug alert for Trimbow inhaler which they had checked in September 2023. 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 as not to cover-up the warning messages. The pharmacy had extra information cards in the event of split packs. The pharmacy used dispensing baskets to keep medicines and prescriptions together during the dispensing process. This helped to manage the risk of items becoming mixed-up.

The pharmacy supplied medicines in multi-compartment compliance packs to a substantial number of people to help them with their medication. The pharmacy used a large rear area to assemble and store the packs to keep dispensing organised safe. Supplementary records helped team members plan and dispense the packs to ensure people received their medication at the right time. And they referred to records that provided a list of people’s current medication and the time of the day it was due. They checked new prescriptions for accuracy and kept records up to date following changes. But the RP did not always clinically check and annotate prescriptions. And the ACPT conducted final accuracy checks when the RP had not clinically checked and annotated some prescriptions. Some people arranged collection of their packs either by themselves or by a representative. And team members monitored the collections to confirm they had been collected on time. This helped them to identify when they needed to contact the relevant authorities to raise concerns.

The pharmacy dispensed serial prescriptions for people that had registered with the Medicines: Care and Review service (MCR). The pharmacy had a system for managing the dispensing of serial prescription dispensing. And they retrieved prescriptions in advance once a week so they could order items and dispense them in good time. Most people collected their medication on time. And team members knew to inform the pharmacist when people did not collect when they expected them to. The pharmacy used a collection point machine, and a substantial number of people accessed the machine to collect their prescriptions. This included when the pharmacy was closed. Some medications were not placed in the machine, such as controlled drugs and fridge items due to safe storage requirements. And team members checked and removed prescriptions after three days and contacted people to tell them.

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 separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy kept a blood pressure monitor, but team members could not show when it had last been calibrated. 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. The pharmacy used a collection point and people could access to collect their prescriptions when the pharmacy was closed. Team members knew to contact the manufacturer's service line when they needed help. They were able to conduct some repairs remotely and they attended the pharmacy to resolve more complex problems.

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.