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: 22/05/2024

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 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 team members work to professional standards to 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 the pharmacy's working practices in a range of relevant standard operating procedures (SOPs) and they were readily available for team members to access whenever they needed to. The superintendent pharmacist (SI) had approved and issued new pharmacy SOPs in October 2023 and team members had read and signed them to confirm their understanding. The regular pharmacist monitored ongoing compliance with SOPs and provided extra support when improvement was needed. A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This helped the pharmacist and the accuracy checking dispensers (ACDs) to identify and help team members learn from their dispensing mistakes. This included recording and monitoring errors identified before they reached people, known as near miss errors. They discussed these errors with the individual team members to agree actions and to manage dispensing risks. This included separating medicines with similar names, such as Symbicort inhaler and Symbicort Turbohaler, and ropinirole and risperidone tablets to manage selection risks.

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 how to manage risks 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 and verified the balances once a week. The pharmacy kept records of CDs that people returned for disposal and a signature audit trail provided assurance that 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. The pharmacy trained its team members to safeguard sensitive information. This included using a shredder to dispose of confidential waste safely and securely.

The pharmacy trained its team members to identify vulnerable adults and children. 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. The pharmacy displayed a chaperone policy in the waiting area and this informed people that they could be accompanied whilst speaking to team members in the consultation room.

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 pharmacy regularly reviewed its staffing levels and skill mix arrangements and made improvements when there were shortfalls. The pharmacy had recently recruited two new team members in the last few months to replace individuals who had left. It had also enrolled an experienced dispenser onto an accuracy in dispensing course to support the pharmacist carry out final accuracy checks. The regular pharmacist had been moved to another branch and had temporarily swapped positions with the pharmacist who usually worked there. The following team members were in post; a full-time pharmacist, one full-time accuracy checking dispenser (ACD), one part-time ACD, one full-time dispenser who was also employed as the pharmacy supervisor, four part-time dispensers, one full-time dispenser, one full-time trainee dispenser, one part-time trainee dispenser, one part-time medicines counter assistant and four part-time delivery drivers. The pharmacy had minimum staffing levels in place with only one team member permitted to take leave at the one-time unless there were exceptional circumstances. An experienced part-time dispenser had temporarily increased their hours and were providing cover at the time of the inspection for someone who was on leave.

The pharmacy had informal induction arrangements in place that new team members followed. They read and signed the pharmacy's SOPs to confirm they understood and would adhere to them. And they shadowed the other team members before the pharmacist deemed them competent to carry out tasks on their own. The pharmacist enrolled new team members onto qualification training within the necessary timescales and they provided protected learning time in the workplace. This ensured they were supported in their studies and made satisfactory progress. The pharmacy encouraged and supported experienced team members to enrol on ACD training, and the pharmacist was about to undertake independent prescribing training. The pharmacist ensured team members kept up to date in their roles and responsibilities. They discussed near miss errors and improvements to keep services safe and effective. They also discussed new initiatives, for example a new patient group direction (PGD) to treat sore throats. This ensured team members knew to refer people to the pharmacist when appropriate to provide the necessary treatment. The pharmacist also discussed legislative changes and team members knew only to dispense full packs of valproate-containing medication unless in exceptional circumstances.

The pharmacist encouraged team members to provide feedback and suggest service improvements. The team had recently suggested changing the day the pharmacy dispensed some medicines. This was due to the pharmacy's staffing levels and when there were more team members on duty. This was agreed and had helped with the pharmacy's workload. A new medicines counter assistant suggested re-arranging a stock room so that items were better organised and easier to find. This involved labelling storage baskets to clearly show the contents for team members to access in a timely manner. The supervisor had called a meeting with the pharmacy team to plan the day's activities. This was due to the

absence of the regular pharmacist and a new locum pharmacist providing cover for the day. 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 a modern purpose-built premises and 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 final accuracy checks that were carried out by pharmacists and ACDs. A rear bench was used to assemble and label multi-compartment compliance packs. This ensured there was sufficient space for the prescriptions and the relevant documentation to keep dispensing safe. The pharmacist 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. It also had a separate booth where people could also be seen in private. 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 access via a level entrance which helped people with mobility difficulties.
A range of patient information leaflets helped people understand health conditions and available treatments.

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. They attached labels to packs to highlight short-dated items.
The pharmacy used three fridges 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 fridges were organised with items safely segregated which helped team members manage the risk of selection errors. They used clear bags for items they had previously dispensed and awaited collection. This made retrieval easier and helped with the necessary safety checks that were required before making a supply. Team members used four 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. 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 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. Team members dispensed a considerable number of multi-compartment compliance packs (MDS) over a four-week cycle. The pharmacist carried out clinical checks and annotated prescriptions so that the ACDs knew when they were authorised to check them. Team members used supplementary records to carry out the necessary checks. This helped to confirm people’s prescription requirements and to identify any changes which they queried with the surgery. Team members checked the expiry dates at the time of dispensing, but they did not always provide the original packaging for the pharmacist and the ACDs to refer to during the final accuracy check. And sometimes they only provided the ends of the packs. This

meant that sometimes the batch number and the expiry date were missing, and they were unable to confirm that items were within their expiry date. Team members printed weekly sheets that showed when supplies were due. This provided the delivery driver with a schedule to follow and to make sure they completed all the deliveries within the necessary timescales so that people received their medications on time.

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 substance misuse medicines. They had highlighted the measures, so they were 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.

The pharmacy used a collection point for people that wished to collect their medicines when the pharmacy was closed. And team members knew how to contact the service provider whenever there were operating problems. They were able to resolve the problems and recalibrate the machine remotely. The pharmacy used a blood pressure machine, but they had not considered the need for recalibrations and there was no record of when it had been first used.

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.