General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pines Pharmacy, Unit 1 The Pines, 5 Fleming Court, DENNY, Stirlingshire, FK6 5HB

Pharmacy reference: 1121888

Type of pharmacy: Community

Date of inspection: 18/07/2024

Pharmacy context

This is a community pharmacy in Denny. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy has not enrolled all its drivers on accredited training as required.
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 has most of the written procedures it needs relevant to its services. And team members mostly follow these to help them provide services safely. They discuss mistakes that happen when dispensing. And they keep some records to identify patterns in the mistakes and reduce the risk of errors. The pharmacy mostly keeps accurate records as required by law, and it protects people's 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 team members had access to them whenever they needed to refresh their knowledge. 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 and ongoing compliance. The folder containing the SOPs showed a range of documented procedures, such as for controlled drugs (CDs) and responsible pharmacist (RP) regulations. It also included new SOPs for the operation of the pharmacy's automated dispensing machine they had introduced since the last inspection. But the pharmacy had not defined the procedure for carrying out final accuracy checks for the pharmacist and the accuracy checking dispenser (ACD) to follow. The pharmacist and the ACD had worked at another branch up until May 2024 and they agreed to contact the branch to obtain a copy of the SOP that they had developed and implemented for use there. The pharmacist knew to use a checking stamp and to annotate prescriptions they deemed suitable for the ACD to accuracy check. And the ACD knew to accuracy check only those prescriptions that the pharmacist had annotated. The new pharmacist had been carrying out risk assessments since they took up their position around May 2024 and they were in the process of making safety improvements. They had introduced an extra check when team members issued CDs. And they knew to obtain an accuracy check from the pharmacist when they removed multi-compartment compliance packs from the CD cabinet before they supplied them.

A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This helped the pharmacist and the ACD to identify and help team members learn from their dispensing mistakes. Team members provided the container ends of the cardboard packs to show the name of the medication and its batch number and expiry date for multi-compartment compliance pack dispensing. But they did not always provide the bulk packs that they had used, for example large tubs of paracetamol tablets that were being used to dispense other packs at the same time. This meant the necessary information was not always available to allow the pharmacist and the ACD to safely carry out final accuracy checks, such as checking the expiry date of medicines. The pharmacy had introduced an automated dispensing machine for most of its prescriptions. And team members loaded most of the pharmacy stock into the machine. They excluded some items, such as higher risk medicines, large packs and those requiring refrigeration. Team members confirmed this had improved accuracy in dispensing.

The pharmacy had not defined the process for team members to follow to report errors identified before they reached people, known as near miss errors. The ACD kept records of errors with multi-compartment compliance pack dispensing. But there were no such records of errors for all other prescriptions. Team members provided some examples of improvement action to manage dispensing risks. This included separating Trelegy and Relvar inhalers due to similar packaging. And putting Aero

chambers for adults and children in separate baskets on the shelf. A team member responsible for dispensing higher-risk medicines identified the risk of incorrect supplies due to people with similar sounding names. And they had placed the prescription items in different coloured baskets so that team members were alerted to the risk of items being mixed up. The pharmacy defined its complaints procedure in a documented SOP and team members 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 mostly up to date. But locum pharmacists that worked at the weekend did not always enter the time they finished.

The pharmacy had made some improvements to CD management since the last inspection. The pharmacy had a process whereby invoices and prescriptions were kept in a basket to ensure the RP entered them in the CD registers before the end of the day. From a sample checked the current CD registers were up-to-date and complete. These were paper-based registers that the team had implemented in January 2024. Some of the historical issues in the electronic register were not yet resolved. From May 2024, checks of the physical quantity of CDs against the register running balance had been weekly, according to the SOP. Before this the checks had been less frequent.

Team members filed prescriptions so they could easily retrieve them if needed. They kept records of supplies of unlicensed medicines. And they had re-introduced the legal register they used for supplies against private prescriptions since the last inspection and records were up to date. 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 defined its safeguarding of vulnerable people procedure in a documented SOP and team members knew when to escalate concerns and 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 not all met**

Summary findings

The pharmacy has enough team members to manage the workload. But it does not enrol all its team members on the necessary qualification training as required by the GPhC. The pharmacy supports those team members who are enrolled on courses to complete their training. It encourages team members to provide feedback to improve its services.

Inspector's evidence

The following team members were in post; a full-time pharmacist, one part-time accuracy checking dispenser (ACD), four full-time dispensers, two full-time trainee dispensers, two part-time medicines counter assistants (MCAs), one part-time trainee MCA and five delivery drivers. Two of the drivers had worked at the pharmacy for more than five years, but three of the drivers had taken up post in the last two years. And the pharmacy had not enrolled them on the required accredited training which was identified at the last inspection. 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. But the pharmacy had four team members on leave at the time of the inspection. The pharmacist confirmed that service continuity had not been affected due to local holidays and the pharmacy continued to operate safely and effectively. At the time of the inspection team members worked in a calm, orderly manner and people continued to receive their medication when it was due. The company arranged locum pharmacists to provide cover for the regular pharmacist when they were off. This included cover so they were supported to undergo qualification training to become an independent prescriber.

The pharmacist provided protected learning time in the workplace. They supported team members during their training, so they made satisfactory progress. The pharmacist ensured team members kept up to date in their roles and responsibilities. They discussed new initiatives, which included a new patient group direction (PGD) that the health board had issued 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 changes and had provided training about the new pregnancy prevention measures for topiramate medication.

The pharmacist encouraged team members to provide feedback and suggest service improvements. The team had recently suggested changes to the layout at the medicines counter to keep medicines safe and this had been agreed. Team members discussed near miss errors. One of the dispensers had suggested alphabetizing the large quantity of tubs of medicines that they used for multi-compartment compliance pack dispensing to manage the risk of selection errors and this also had been agreed. The pharmacy had a documented SOP that defined the process for raising whistleblowing concerns and it trained team members, so they understood their obligations to do so. 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 good 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 the checks that were carried out by the pharmacist and the ACD. Rear benches were used to assemble and label multi-compartment compliance packs. This ensured sufficient space for the prescriptions and the relevant documentation to carry out the necessary checks and keep dispensing safe. The pharmacist had good visibility of the medicines counter and could intervene when necessary.

The pharmacy had two consultation rooms that provided an environment for people to speak freely with the pharmacist and other team members during private consultations. A clean, well-maintained sink in the dispensary was used for medicines preparation. And team members cleaned 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 ramped entrance which helped people with mobility difficulties, and it provided some information about its services and opening hours in the front window. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted some monitoring activities to confirm that medicines were fit for purpose. The pharmacy arranged an annual stock take which included a date check of all its items and team members confirmed they checked expiry dates at the time of dispensing. The pharmacy used an automated dispensing machine for original pack dispensing. The machine displayed a list of items that had already expired. But on removal for inspection, a team member found they had not expired and were well within their expiry date. A random check of dispensary stock found no out-of-date medicines.

The pharmacy used a large 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 kept CDs secure and medicines were organised with some items segregated awaiting an authorised destruction by the health board. The pharmacy received drug alerts and recall notifications. The pharmacist checked the notifications, and provided an example of a recent drug alert. But they did not keep an audit trail to show they had conducted the necessary checks. 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 different coloured containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. It also helped them prioritise prescriptions, for example, they used a red basket for people that wished to wait on their medication. Team members dispensed a considerable number of multi-compartment compliance packs over a four-week cycle. The pharmacist carried out a clinical check on all the prescriptions and they used a stamp to annotate their signature, so the ACD knew when they were authorised to check them.

Team members 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 also kept a schedule to show when people's compliance

packs were due for delivery. They retrieved the packs from the shelf and these were checked against the schedule to ensure they were correct. Team members supplied patient information leaflets (PILs) with the first pack of the four-week cycle. And they provided descriptions on the packs of individual medicines to help people identify their 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 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 to contact the service provider whenever there were operating problems. The service engineer had recently attended the pharmacy to resolve a malfunction caused by an address label on a prescription bag. The pharmacy used an automated dispensing machine, and an annual service schedule was in place. This was due around November 2024. The pharmacy used a blood pressure machine, but team members 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.