General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Browns Pharmacy Healthcare, 43-51 North Methven Street, Perth, PH1 5PX

Pharmacy reference: 9011736

Type of pharmacy: Community

Date of inspection: 31/07/2023

Pharmacy context

This is a community pharmacy on a high street in the city centre of Perth. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It delivers medicines for some people to their homes and supplies some people with their medicines in multi-compartment compliance packs to help them with taking their medicines. The pharmacy team advises on minor ailments and provides the NHS Pharmacy First service. The pharmacy has a 24-hour collection point which allows people to collect their dispensed medicines at any time, including outside of the pharmacy's opening hours.

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 manages risks to help team members provide safe services. And it keeps the records it needs to by law. Team members record mistakes they make when dispensing but they do not review the records regularly. And therefore, they may miss opportunities to identify trends and patterns. Team members know how to help support vulnerable people and protect their welfare. And they keep people's private information safe.

Inspector's evidence

The pharmacy had a comprehensive set of standard operating procedures (SOPs) to help team members work effectively. But they had not been reviewed since 2018 so they may not consider changes to processes that have been implemented. Team members read the SOPs relevant to their role and completed a record of competence signature sheet to confirm their understanding of them. They advised that they read these regularly to refresh their knowledge but there was not an updated signature sheet to confirm this. Team members were observed working within the scope of their roles. The pharmacy had recently started using an automated dispensing machine for multi-compartment compliance packs. There were SOPs for this operation and the superintendent (SI) had completed a risk assessment. Team members were aware of the responsible pharmacist (RP) regulations and of what tasks they could and couldn't do in the absence of an RP.

Pharmacy team members recorded mistakes they identified during the dispensing process, known as near misses, on an electronic near miss record. They explained errors were highlighted to them by the pharmacist, and it was their responsibility to enter them onto the record. This allowed them to reflect on the mistake. Team members had identified a number of medicines that looked or sounded alike and distinctly separated them on the dispensary shelves to avoid them being mixed up. For example amiloride and amlodipine tablets. The pharmacy manager previously reviewed the near miss records monthly, but they had not done this recently so opportunities to identify and review common trends might be missed. Team members also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. These incidents were recorded on an electronic platform and were then reviewed by the SI. The team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the pharmacist manager or SI.

The pharmacy had current professional indemnity insurance. The RP notice displayed contained the correct details of the RP on duty, and it could be seen clearly from the retail area. The RP record was appropriately maintained. The controlled drug (CD) register was kept electronically and appeared to be in order. Running balances were recorded and they were checked against the phsyical levels every month and on the receipt of new stock. A record of patient returned CDs was maintained and up to date. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were recorded to provide an audit trail. Accurate records of private prescriptions were maintained.

An NHS Pharmacy First Privacy notice was displayed in the retail area. Team members were aware of the need to keep people's information confidential. Confidential information was stored in staff-only areas of the pharmacy. Team members separated confidential waste in dedicated waste bags which

were collected periodically by a third-part contractor for secure destruction. And they also had access to a shredder. Pharmacy team members had completed learning associated with protecting vulnerable people. They understood their obligations to manage safeguarding concerns and were familiar with common signs of abuse and neglect. And they had access to contact details for relevant local agencies.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to manage its workload. Team members have the correct training for their roles and complete some regular training to maintain their knowledge and skills. They receive some feedback about how they are performing, to help them improve. And they know who to raise concerns with should they need to.

Inspector's evidence

The pharmacy employed a full-time pharmacist manager and the SI supported on a part-time basis. There was a large, experienced pharmacy team that included an accuracy checking technician (ACT). Team members had all completed accredited training or were enrolled on an accredited training course. And their certificates of qualification were on display in the pharmacy. A pharmacist who worked at another pharmacy owned by the same company acted as a buddy to the trainee dispensers. And they also received support from the regular pharmacist. A foundation pharmacist was due to start the following day and the pharmacist had completed all mandatory training from NHS Education for Scotland to support them. Team members were observed working well together and managing the workload. Only experienced team members worked in the areas of the pharmacy that were not under the direct supervision of the pharmacist. Trainee team members always worked in the main dispensary or with another experienced team member so that they had more support. A task rota was displayed in the dispensary to help the team manage responsibilities. Planned leave requests were managed so that only two team members were absent at a time. Part-time staff supported by working additional hours during periods of planned leave. And there was additional support available from the near-by pharmacy owned by the same company.

Team members enrolled on accredited training courses received protected learning time. And they had a monthly meeting with their buddy pharmacist to review progress. They also had access to an online learning platform where they completed training relevant to their role such as over-the-counter consultation skills. The ACT had recently completed training via webinar on the NHS Turas platform. The SI and dispenser had received face to face training for the automated dispensing machine. The team felt comfortable to raise any concerns to their SI or pharmacist manager. They did not currently have formal appraisal meetings, but they received feedback as they worked. The pharmacy did not have a whistleblowing policy in place so the team may not know how to raise concerns anonymously. There were no targets set for pharmacy services.

Team members were observed asking appropriate questions when selling medicines over the counter and referring to the pharmacist when necessary. They explained how they would identify repeated requests for medicines subject to misuse, for example, codeine containing medicines. And that they would refer repeated requests to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided and are appropriately maintained. The pharmacy reviews and improves its premises and facilities to ensure they remain appropriate. It has a suitable consultation room where people can have a confidential conversation with a pharmacy team member.

Inspector's evidence

The large premises were secure, modern, and provided a professional image. They had recently been extended to include an additional storage room and dispensary area where multi-compartment compliance packs were prepared using an automated dispensing machine. The pharmacy workspaces were well organised with designated areas for completion of pharmacy tasks and suitable storage for prescriptions. The main dispensary area had a separate area where team members could work if required to reduce distractions. There was an additional dispensary area located in the basement that was used specifically for preparation of medicines for people living in a care home. There were various storage areas and two staff rooms that were kept clean and tidy. The retail area was completely screened with a Perspex screen that had been installed during the Covid-19 pandemic, but the team had chosen to keep this in place. There were two consultation rooms available which were kept locked when not in use. But only one of these was in regular use to have fully private conversations with people.

There was a clean, well-maintained sink in the dispensary used for medicines preparation and there were other facilities for hand washing. The pharmacy kept heating and lighting to an acceptable level in the dispensary and retail area. There were chairs in the retail area that provided a suitable waiting area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of accessible services that support people's health needs. The pharmacy appropriately manages its services. It obtains its medicines from reputable sources. And it stores and manages them as it should. The pharmacy has a well-managed 24-hour collection point to allow people to collect their medicines at any time of day including outside of the pharmacy's opening hours. And the automated dispensing system is regularly reviewed to provide assurance it is operating safely and effectively.

Inspector's evidence

The pharmacy had good physical access with a level entrance and a semi-automatic door with touch pad. And there was an internal ramp to access the retail area. It displayed its opening hours and some pharmacy services in the window. The team also kept a range of healthcare information leaflets for people to read or take away, these included information on NHS Pharmacy First Service and Medicines: Care and Review Service (MCR). There was access to a hearing loop for people with a hearing impairment. And access to translation services via telephone to provide services to people who could not speak English.

The main dispensary had separate areas for labelling, dispensing, and checking of prescriptions. Team members used baskets to store medicines and prescriptions during the dispensing process to prevent them becoming mixed-up. These were colour coded to enable team members to identify the type of prescription stored within and to manage workload. There were various shelving areas for storage of prescriptions awaiting an accuracy check, this ensured the dispensary benches remained clear. Team members signed dispensing labels to maintain an audit trail. They provided owing's slips to people when it could not supply the full quantity prescribed. And they contacted the prescriber when a manufacturer was unable to supply a medicine. The pharmacy offered a delivery service and kept records of completed deliveries using a handheld device. Team members were able to track progress of deliveries using an electronic platform so could answer queries from people expecting deliveries. An additional delivery record book was maintained for higher risk deliveries including CDs, medication requiring cold storage and care home deliveries.

Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to avoid covering up written warnings on the packs with dispensing labels. The pharmacy supplied patient information leaflets and patient cards with every supply. Following a recent review, no people currently prescribed valproate were identified as being in the at-risk group. Team members attached various alert stickers to prescriptions. They used these as a prompt before they handed out medicines to people who may require further intervention from the pharmacist.

The pharmacy provided multi-compartment compliance packs to a large number of people to help them take their medication correctly. And it provided the service as a hub dispensary for the other pharmacy in the company, known as the spoke pharmacy. A dedicated team member managed this process and used an automated dispensing system for the majority of the packs. Team members used medication record cards that contained each person's medication and dosage times. They ordered peoples repeat prescriptions and reconciled these against the medication record card. The prescription

data was entered into the patient medication record (PMR) by a dispenser, it was clinically checked by the RP and accuracy checked by the ACT. The data was then transferred to the automated dispensing machine for assembly. The computer system that accompanied the dispensing machine took photographs of each pack. If any errors were found, the pack was rejected and required to be manually checked. And a photograph of each medication which printed onto the labels and attached to the packs so people could differentiate between the different medicines in the pack. A description of each medicine was also added by the dispenser. A sample of dispensed compliance packs were seen to have been labelled with descriptions and photographs of the medication. Patient information leaflets were not routinely supplied so people may not have access to up-to-date information about their medicines. Photographs of the packs were stored on the PMR and able to be recalled in the event of any queries.

The SI had accuracy checked the compliance packs following assembly for the first six weeks after installation of the automated dispensing machine. And they had found the dispensing machine to be 100% accurate. They completed ongoing quality assurance by accuracy checking 2% of all packs assembled. No errors have been identified relating to the assembly process.

The team used barcodes to manage stock in the automated dispensing machine. The stock was de-blistered and placed into canisters and each canister contained the same batch number and expiry date so that there were no mixed batches. Barcodes were used to manage the stock and the barcodes from the canister and the stock boxes were scanned before as an accuracy check. A dispensing assistant kept additional paper records of when the stock had been removed from its original packaging and which members of the team had been involved in the process. A pharmacist, ACT or experienced member of the team performed a second check before the canisters were authorised to be loaded into the dispensing machine.

Team members managed the dispensing of serial prescriptions as part of the MCR service. The prescriptions were made up in advance of people collecting following the scheduled collection date. The NHS Pharmacy First Service was popular. This involved supplying medicines for common clinical conditions such as urinary tract infections under a patient group direction (PGDs). The pharmacist had current printed copies of the PGDs and could access these electronically. The pharmacy also supplied medicines with medication administration records to vulnerable adults living in an assisted living facility.

The pharmacy had an automated 24-hour collection point. The collection point allowed people to collect their medicines at any time of day, including outside of the pharmacy’s opening hours. Team members asked people for written consent to allow them to store their medicines in the collection point. If they agreed, they were sent a text message indicating their medicines were ready to collect with a pin code. The pin code was used to enter on the touch screen system and the prescription could be collected in the collection drawer.

Pharmacy-only (P) medicines were stored behind the pharmacy counter and Perspex screen to prevent unauthorised access. The pharmacy obtained medicines from licensed wholesalers and stored these tidily on shelves. And it used a medical grade fridge to keep medicines at the manufacturers' recommended temperature. Team members monitored and recorded the temperature every day. This provided assurance that the fridge was operating within the required range of between two and eight degrees Celsius. Team members checked the expiry dates of medicines weekly. Short-dated stickers were used to highlight medicines which were due to expire soon. The team advised that they were up to date with the process and had an audit trail to demonstrate completion. A random selection of medicines were checked and all were found to be within their expiry date. The pharmacy received notifications of drug alerts and recalls via email. Team members carried out checks and knew to remove

and quarantine affected stock. They returned items received damaged or faulty to manufacturers as soon as possible. The pharmacy had medical waste bins for pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to support the safe delivery of its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources including the British National Formulary (BNF), the BNF for children and the NHS Tayside Pharmacy First Formulary. There was also access to internet services. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. The automated dispensing machine for multi-compartment compliance packs and the automated 24-hour collection point were serviced regularly by the external providers. And engineer support was available via telephone for both machines. All electrical equipment was subject to yearly Portable Appliance Testing (PAT) which gave assurance it was safe to use.

The pharmacy stored dispensed medicines awaiting collection, in a way that prevented members of the public seeing people's confidential information. The dispensary was screened, and computer screens were positioned so that unauthorised people couldn't see any confidential information. The computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones so team members could move to have private conversations with people.

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.