General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Browns Pharmacy Healthcare, 195 High Street, Perth, PH1 5UN

Pharmacy reference: 9012223

Type of pharmacy: Community

Date of inspection: 21/11/2024

Pharmacy context

This is a community pharmacy in Perth. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy dispenses private prescriptions and pharmacy team members advise on minor ailments and medicines use. They provide 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 has relevant written procedures for the services it provides, and team members read and follow them. Team members discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes to make safety improvements and reduce the risk of errors. The pharmacy keeps accurate records as required by law, and it keeps people's confidential information 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 standard operating procedures (SOPs) which were accessible to team members. The superintendent pharmacist (SI) had approved and issued SOPs. And the documents showed they were due to be reviewed and updated in 2025. SOPs included checking procedures for the accuracy checking dispenser (ACD) and the accuracy checking pharmacy technician (ACPT) to follow. And they knew only to check prescriptions that had been clinically checked and annotated by a pharmacist. The pharmacist manager confirmed that team members had read the SOPs. But the relevant records had not been annotated to confirm their understanding and ongoing compliance. Team members were seen to be following safe working practices at the time of the inspection.

A signature audit trail on medicine labels showed who was responsible for dispensing each prescription. This meant the pharmacist, the ACD and the ACPT were able to identify and help team members learn from their dispensing mistakes. The pharmacy kept records of dispensing mistakes that were identified in the pharmacy, known as near miss errors. And the ACD was responsible for carrying out a near miss review that highlighted any patterns and trends to help the pharmacy team identify and manage dispensing risks. Team members provided examples of improvement action. This included separating look alike, sound alike (LASA) medications. For example, they had separated the different strengths of amlodipine to reduce the risk of dispensing mistakes. They had also agreed to reflect on their use of the pharmacy's 'five-tick' method of checking items to ensure they followed it to reduce the frequency of near miss errors. This involved ticking the name, strength, formulation, quantity, and expiry date on the dispensing label to confirm the accuracy of each item they dispensed.

Team members knew to escalate dispensing errors, which were mistakes that were identified after a person had received their medicine. The pharmacist discussed the incidents with team members, so they learned about risks and knew how to keep dispensing services safe. The pharmacist knew to complete an incident report which they shared with the SI so they could intervene and implement extra improvements if necessary. Team members also completed a reflective statement for dispensing mistakes that involved higher-risk medicines. This helped them to identify improvement action and to manage the risk of a future recurrence. The pharmacy defined its complaints procedure in a documented SOP and team members knew to handle any concerns that people raised in a calm and sensitive manner. Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed an RP notice which was visible from the waiting area, and they kept the RP record up to date.

Team members maintained CD registers and they checked the balance recorded in the register matched

the physical stock, once a month. The pharmacy knew to keep records of CDs that people returned for disposal and to annotate the records to provide an audit trail to show when destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed. They kept records of supplies of unlicensed medicines and private prescriptions which were accurate and correct. The pharmacy trained its team members to safeguard sensitive information. This included managing the safe and secure disposal of confidential waste which was collected by an approved provider for off-site disposal. The pharmacy defined its safeguarding procedure in a documented SOP and team members knew to escalate any safeguarding concerns and discuss them with the pharmacist to help vulnerable people. For example, when some people failed to collect their medication on time so that alternative arrangements could be arranged if necessary.

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. It regularly reviews pharmacy team members performance so they can improve and develop in their roles. And it encourages team members to provide feedback and suggest improvements to improve working practices.

Inspector's evidence

The pharmacy's dispensing workload had increased since it had relocated in August 2024. The SI monitored the workload to ensure the pharmacy had the right number of suitably skilled team members. The following team members were in post; one full-time pharmacist manager, one part-time pharmacist that worked alongside the pharmacist manager on a Monday and a Friday, a full-time ACPT, a full-time ACD, three full-time dispensers, two part-time trainee medicines counter assistants (MCAs), one full-time MCA, two full-time delivery drivers, one part-time delivery driver and one trainee MCA that worked every Saturday. The pharmacy had contingency arrangements in place to ensure there were adequate team members working when it needed them. For example, the ACD and ACPT did not take annual leave at the same time to ensure the pharmacist was supported in their clinical roles. Another pharmacy owned by the same company was located nearby, and both pharmacies shared team members to provide cover when necessary.

The pharmacy had induction arrangements in place so that new team members complied with the pharmacy's governance arrangements. This included topics such as health and safety, medicines sales protocols and reading the pharmacy's SOPs. The pharmacist supported team members to learn and develop in their roles and they provided protected learning time for them to do so. This ensured the team members undergoing accredited courses made satisfactory progress. They were also provided with extra support when necessary. The pharmacist was undergoing independent prescribing (PIP) training and regular locum pharmacists had been arranged to provide backfill. They had also completed the relevant training so they could provide a travel vaccination clinic. Team members had been trained to deliver a smoking cessation service. And they provided weekly support for people after the initial consultation with the pharmacist. The pharmacist provided ad-hoc training as and when it was needed. This had included updating the pharmacy team about changes to the patient group direction (PGD) to treat scabies due to a recent outbreak. They had also discussed the introduction of Evana medication, a new treatment that was available to buy over the counter without a prescription. This meant they would know when to refer requests to the pharmacist to keep people safe.

The SI empowered team members to make suggestions for change and they regularly discussed areas for improvement. Team members provided a few examples of recent changes that had increased the safety and effectiveness of the pharmacy's working arrangements. This included changes to the way they managed serial prescriptions which involved retrieving prescriptions a week before they were due. This meant that medicines were ordered and dispensed in good time. The ACPT and the ACD had also suggested carrying out accuracy checks in a quiet upstairs dispensary. This had helped minimise distractions and minimise the risk of errors. The pharmacist encouraged team members to raise whistleblowing concerns to help to keep pharmacy services safe and effective.

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 new, modern purpose-built premises that presented a professional appearance to the people that used it. The dispensary was well-organised with separate dedicated areas for the dispensing and checking of prescription items. This included a large upstairs dispensary that team members used for multi-compartment compliance pack dispensing. Team members ensured the area was free from other items. This ensured sufficient space for the prescriptions and the relevant documentation to carry out the necessary checks and keep dispensing safe. Team members used dispensing baskets to help organise the workspace on the dispensing benches. And they organised the shelves and kept them tidy to manage the risk of medicines becoming mixed up.

The pharmacy had a consultation room with separate access from the dispensary and from the retail waiting area. It had a sink with hot and cold running water. People could speak to the pharmacist and team members in private. A clean sink in the dispensary was used for medicines preparation and team members cleaned all areas of the pharmacy daily. 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 regularly checks medicines are in good condition and suitable to supply. And they identify and remove medicines from use that are no longer fit for purpose.

Inspector's evidence

The pharmacy was on the corner of a busy main road and a shopping precinct, and it provided its services six days a week from Monday to Saturday. The premises had a step-free entrance and an automated door, and people with mobility issues were able to gain access without restrictions. The pharmacy purchased medicines and medical devices from recognised suppliers and team members conducted monitoring activities to confirm that medicines were fit for purpose. They regularly checked medicine expiry dates which they documented so they knew when checks were next due. The pharmacy kept stocks of medicines used in palliative care. And team members carried out checks to make sure that stock levels were maintained and medicines were fit for purpose and available for use. A random check of dispensary stock found no out-of-date medicines. The pharmacy used two fridges to keep medicines at the manufacturers' recommended temperature. And team members monitored 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. The pharmacy used secure cabinets for some of its medicines. They were kept well-organised, and items were quarantined whilst they awaited destruction. The pharmacy received drug safety alerts and medicine recall notifications. Team members checked the notifications and maintained 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. It also had clinical waste bins to dispose of the sharps used to provide its travel vaccination clinic and diabetic testing service. 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 safety 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 had carried out risk assessments to confirm that some people were suitable to receive sodium valproate in multi-compartment packs. But they had not documented the risk assessments to provide a record for team members to refer to.

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. It also helped them prioritise prescriptions, for example, for people that wished to wait on their medication. The pharmacy supplied medicines in multi-compartment compliance packs over a four-week cycle. Team members used supplementary pharmacy records to manage the dispensing procedure. They also documented the person's current medicines and administration times which allowed them to carry out checks and identify any changes that they queried with the GP surgery. The pharmacist annotated the

prescriptions to show they had completed a clinical check and team members entered the prescription information onto the pharmacy's patient medication record (PMR). The ACPT and the ACD accuracy checked the prescription information and transmitted it to another of the company's pharmacies, known as the hub pharmacy for dispensing. Once dispensed the hub pharmacy delivered the multi-compartment compliance packs to the pharmacy. Team members matched the items with the prescriptions, and they kept the packs in an upstairs dispensary until they were needed. Team members supplied patient information leaflets (PILs) with the first pack of the four-week schedule, and they provided descriptions on the packs of 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 access to the digital version of the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used an automated dispensing machine for substance misuse medicines. The pharmacist calibrated the machine each morning to ensure it was measuring accurately and team members cleaned the machine at the end of the day. The pharmacy had installed a prescription collection machine at the time of its relocation. And people could collect their medicines out of hours when it was safe to do so. The SI had arranged training before team members were expected to use the collection machine. And they knew who to contact if they experienced problems. 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.