General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gallagher Pharmacy, 1 New Street, DALRY, Ayrshire, KA24 5AH

Pharmacy reference: 1041821

Type of pharmacy: Community

Date of inspection: 24/10/2019

Pharmacy context

This is a community pharmacy in the town of Dalry, Aryshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including a home delivery, a minor ailments service, the NHS Chronic Medicines Service (CMS), a substance misuse service and various medicines through the Pharmacy First service. It supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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	1.1	Good practice	The pharmacy is good at identifying and managing the risks associated with the services it provides to people. It has a comprehensive set of written procedures for the team members to follow to help them deliver the services safely. And the pharmacy helps it team members understand the importance of following these procedures.
		1.2	Good practice	The pharmacy team members are good at recording mistakes that happen during dispensing. They make sure they understand why these mistakes happen. And what they can do to learn from them. They implement changes to minimise the risk of similar mistakes happening in the future.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at supporting its team members to complete training. The team members tailor their training to their own needs to improve their knowledge and skills. And the pharmacy supports the team members with a good amount of protected training time and regular performance appraisals.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy advertises the wide range of services it provides and makes them easily accessible to people. It proactively helps people who do not speak English as a first language, to understand how to take their medicines correctly.
		4.2	Good practice	The pharmacy safely manages how it dispenses medicines and keeps comprehensive audit trails to support this. So, the pharmacy can easily identify any potential mistakes.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy is good at identifying and managing the risks associated with the services it provides to people. It has a comprehensive set of written procedures for the team members to follow to help them deliver the services safely. And the pharmacy helps its team members understand the importance of following these procedures. The pharmacy keeps the records it must have by law and it keeps people's private information secure. It asks people to provide feedback on its services. And following this feedback, it makes changes to its services as a result. The pharmacy team members are good at recording mistakes that happen during dispensing. They make sure they understand why these mistakes happen. And what they can do to learn from them. They implement changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) in place which detailed how the team members should carry out various processes. For example, the taking in and dispensing of prescriptions, the dispensing of medicines in multi-compartmental compliance packs and services such as the Chronic Medicines Service. An index was available, so it was easy to find a specific SOP. Each team member had read the SOP that was relevant to their role. Each SOP had been revised in April 2019 and were due the next review in April 2021. Following the review of each SOP, the team members were given the opportunity to ask questions to help them clarify anything they did not understand or wanted to query. For example, the team questioned the process to confirm people's identity when handing out medicines, as they felt the process was too time consuming. The owners of the pharmacy explained the process was necessary, as the local GP surgeries had on several occasions handed incorrect prescriptions to people. The questions and responses were documented and filed with the SOPs for future reference.

The pharmacy had a process for the team to discuss any near miss errors with all the team members as soon as the pharmacist spotted them. They discussed the error and why it had happened. This helped their learning. Each team member was provided with a book into which they recorded the details of any near miss errors they made. They recorded their errors each time they were made. The details recorded included the time of the error, and the type of prescription, for example 'handwritten'. There was also description of the error, any contributing factors and the action taken to prevent a similar error recurring. A team member showed her latest entry. It described an error involving the strength of a medicine. The team member had selected the medicine for dispensing, without having the prescription in front of her to use as a reference. She explained that she had learned she needed to ensure she kept the prescription with her at all times of the dispensing process to reduce the risk of a similar error happening again. The record was then reviewed by the pharmacist and signed off. Each of the team members near miss errors were analysed at the end of each month by the pharmacist for any trends or patterns. The findings were discussed with the team in a monthly meeting and documented for future reference. The team members had been making a series of errors by mixing up pregabalin and gabapentin. They concluded that the reason for the error was because both medicines had 'GABA' in their names. And so, they often mistook one for the other. To reduce the risk of the errors recurring, the team separated the items in the dispensary by one bay. The team members explained the measure had worked well and they had not had as many similar errors since. The pharmacy had a system to

report and record any dispensing incidents that had reached the patient. Recently the pharmacy had supplied a person with the incorrect strength of a medicine. An incident report summary form was completed, and the pharmacy completed a root cause analysis. The team members explained the reason for the error was because the two strengths were very similar in appearance. And they also noticed that many of the different strengths medicines that were stored in the pharmacy's fridge were also similar in appearance and there was potential for selection errors. The team decided to use clear bags to store dispensed insulin products. This allowed the team members to complete a final visual check of the medicines against the prescription before they handed them out.

The pharmacy had a formal complaints procedure in place. And it was available for people to read in a leaflet available in the retail area. A team member described the complaints procedure and how she would escalate the complaint to the pharmacy's owner if necessary. The pharmacy welcomed feedback from people. And it collected the feedback through verbal conversations between people and the team members, and via questionnaires. The pharmacy had recently relocated the chairs in the waiting area following requests from several people.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of a random CD items matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team were aware of the need to keep people's personal information confidential. And they had all undertaken some basic general data protection regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. A third-party contractor periodically destroyed the confidential waste. The pharmacy outlined to people using the pharmacy how it stored and protected their information. The team members understood the importance of keeping people's information secure.

The pharmacist on duty was PVG registered. The team members gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage and report a concern. And the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely. They work well together to manage their workload and to ensure people receive a high-quality service. The pharmacy is good at supporting its team members to complete training. They can tailor their training to their own needs to improve their knowledge and skills. And the pharmacy supports the team members with a good amount of protected training time and regular performance appraisals. The team members can make suggestions to improve the pharmacy's services. And the pharmacy listens and makes changes. The team members feel comfortable to raise professional concerns when necessary.

Inspector's evidence

At the time of the inspection a locum pharmacist was the responsible pharmacist. And she was supported by a trainee pharmacy technician, a trainee pharmacy assistant and two qualified pharmacy assistants. The regular pharmacist, who worked full-time, a trainee pharmacy assistant, a deliver driver and a counter assistant were not present on the day of the inspection. The regular pharmacist organised the team rotas in advance to ensure enough support was available during the pharmacy’s busiest times. The team members were observed managing the workload well and had a manageable workflow. The team members felt they had enough staff to manage the workload efficiently and they could complete the dispensing workload at their own pace. They said they could speak to the pharmacy’s owners if they needed extra support and they received additional support if they felt they were falling behind with their workload. But this was not common. The team members occasionally worked additional hours to cover absences and holidays. They did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The team members were seen asking the pharmacist for support, especially when they were presented with a query for the purchase of an over-the-counter medicine. They were observed acknowledging people who were waiting to be served as soon as they arrived at the retail counter. They informed people of the waiting time for prescriptions to be dispensed and took the time to speak with them if they had any queries. Several of the team members had worked at the pharmacy for several years and knew many of the people who used the pharmacy by their first names. A pharmacy assistant explained he had a good relationship with many people in the local community and enjoyed being able to help them manage their health better and provide them with advice on living more healthily.

At the time of the inspection, the trainee pharmacy assistant was completing training as part her dispenser training course. She was currently working through a module on safeguarding vulnerable adults and children. The assistant received approximately four hours a week of protected training time. This helped her complete the course without any distractions. She was observed working competently and asking for advice when she needed it. She felt well supported by the team and was comfortable in discussing any stages of her training she found difficult. Other team members not undergoing qualification training, received around an hour of protected training time per week. They were able to tailor their training to their own needs but were often asked to complete a specific module at the request of the regular pharmacist. For example, they had completed training on footcare, menopause and joint pain. The pharmacy kept records of the training the team completed. The pharmacy had an

appraisal process in place for its team members. The appraisals took place every year. The appraisals were an opportunity for the team to discuss which aspects of their roles they enjoyed, where they wanted to improve and if they wanted to give any feedback to improve the services the pharmacy offered. A team member had recently been given extra support to help her become more competent in using the pharmacy's computer systems.

The pharmacy held monthly meetings for the team. The regular pharmacist led the meetings. The pharmacy's superintendent pharmacist often attended the meetings. And they discussed topics such as company news and patient safety, when the pharmacy was quiet. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members felt comfortable to give feedback or raise concerns to help improve the pharmacy's services. For example, they had been concerned about the location of a computer terminal they used to generate dispensing labels. They felt it was too close to the retail area and it meant they often had to break off from the dispensing process to serve people waiting in the retail area. And so, there was an increased risk of them making errors. To improve, the computer terminal was moved away from the retail area. The pharmacy had a whistleblowing policy. The team were not set any targets to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a suitable consultation room where people can speak to the team members privately.

Inspector's evidence

The pharmacy was modern in appearance, both from the outside and inside the premises. It was clearly identifiable as a pharmacy from outside. And it was clean, tidy and well maintained. Floor spaces were clear to prevent the risk of a trip or a fall. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC. It was kept clean and had a sink with hot and cold running water and other facilities for hand washing.

The pharmacy had a consultation room for the team to use to have private consultations with people. It contained two seats and a sink. The room was positioned in the middle of the dispensary. And people had to walk past shelves where the pharmacy stored bagged up medication ready for collection. The pharmacy prevented the risk of people’s names and address’ being seen by using screens to cover the bags before people were asked to make their way to the room. There was a separate booth used for people who were enrolled on the substance misuse service. This gave them additional privacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises the wide range of services it provides and makes them easily accessible to people. It proactively helps people who do not speak English as a first language, to understand how to take their medicines correctly. The pharmacy safely manages how it dispenses its medicines and keeps comprehensive audit trails to support this. So, the pharmacy can easily identify any potential mistakes. The pharmacy provides medicines to some people in multi-compartmental compliance packs to help them take them correctly. And it manages the risks associated with the service well. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had level access from the street to the entrance door. Which allowed people with prams and wheelchairs to enter the pharmacy unaided. The pharmacy could supply people with large print dispensing labels if needed. It also provided a special printed direction sheet in various languages to help people to take medicines. A team member showed how she would circle the English direction on the sheet, which had the translation printed underneath. For example, she would circle, ‘take one’, ‘three times’ and ‘per day’. The pharmacy had provided the sheets to a family who did not speak English and had recently moved to the area.

The pharmacy advertised its services and opening hours in the main window. It stocked a small range of healthcare related leaflets in the retail area, which people could select and take away with them. There were several informative posters attached to the retail counter, including one providing information on eye care support from NHS Ayrshire. The pharmacy provided a repeat prescription request service and there was a poster in the retail area outlining the service. It showed the day a person could expect their medicines to be ready for collection depending on the day they made the request. For example, if the person ordered their medicines on a Monday, their medicines would be ready on Thursday.

The team members regularly used various stickers during dispensing and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They also stamped each prescription with a five-section stamp. Each team member signed the section of the stamp which corresponded to the part of the dispensing process that they completed. So, the pharmacy kept an audit trail of who had selected the medicines, generated the dispensing labels, dispensed the medicines, completed the accuracy check and completed the clinical check. The team members used baskets to hold prescriptions and medicines. This helped the them stop people’s prescriptions from getting mixed up. They placed pharmacist information forms into each basket which brought the pharmacist’s attention to any interactions, changes to medicine doses, forms and strengths and eligibility for services. They recorded the date that CD prescriptions expired on CD alert stickers, which they attached to medication bags. This system helped the team members check the dates and helped prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records included a

signature of receipt. So, there was an audit trail that could be used to solve any queries. It used separate delivery sheets for each person to minimise the risk of a person's personal details being seen by others. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy provided a minor ailment service (eMAS). This was a popular service with the pharmacy completing around ten consultations per day. The team members had completed the relevant training to provide the service. And all the appropriate documentation for the service was seen. The team members used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. A team member was observed advising a person who wanted treatment for a common cold. The pharmacy provided the chronic medicines service (CMS) for people with a long-term condition such as high blood pressure or diabetes. It provided reviews of the way people used their medicines, provided care plans for people and dispensed serial prescriptions which were valid up to 56 weeks. The team annotated the prescriptions to avoid them being mixed up with other types of prescriptions. A SOP of the service was in place. The pharmacy provided a service called Pharmacy First. The service allowed the pharmacy to supply medicines, normally only available with a prescription, to people for various conditions. For example, trimethoprim for urinary tract infections and Fucidin cream for impetigo. The pharmacist went thought a comprehensive conversation with people who wanted to use the service to establish their symptoms and make a diagnosis. The pharmacy kept records of each consultation and supply.

The pharmacy supplied medicines in multi-compartmental compliance packs for around 40 people living in their own homes. And the pharmacy supplied the packs to people on a weekly basis. The team was responsible for ordering people's prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs away from the retail area to avoid being distracted. The pharmacy managed the workload across four weeks to spread the workload evenly. It kept master sheets which the team members used to check off prescriptions and confirm they were accurate. The master sheets detailed the medicines that each person was taking. And the time they would take them. They also kept details of any changes to people's medicines, including the details of the authorising prescriber. And they would update the master sheet each time a change occurred. The packs were supplied with information which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. The pharmacy also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members annotated prescriptions and attached them to people's medication bags to remind them that the bag contained a high-risk medicine. They then alerted the pharmacist when the medicine was being handed out. The pharmacist checked that the person understood their dosage and if they were having regular blood tests if they were prescribed warfarin. And the pharmacist gave the person collecting the medicine additional advice if there was a need to do so. And the pharmacy kept records of the conversations if it was significant. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No-one had been identified.

The pharmacy supplied methadone to several people as part of its substance misuse service. The pharmacist used the booth to the side of the pharmacy counter to speak to people enrolled on the service. The pharmacist checked if people were taking their medicines correctly and if they had any

questions. The pharmacy used bespoke software to manage the service. It kept a photograph of each person and it used a fingerprint recognition device to confirm the identity of each person who came for the service.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines tidily in the dispensary. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next twelve months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits. The pharmacy was complying with the falsified medicines directive (FMD). The team was scanning and decommissioning medicines using the correct scanners and appropriate software. The pharmacy received drug alerts via email. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers to help dispense multi-compartmental compliance packs. It used a Methmeasure system to dispense methadone. It was cleaned and calibrated each day. The fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private. The electrical equipment looked to be in good working order and had been subjected to portable appliance testing in August 2018.

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.