General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gallagher Pharmacy, 41 Hamilton Street, SALTCOATS, Ayrshire, KA21 5DT

Pharmacy reference: 1092870

Type of pharmacy: Community

Date of inspection: 12/09/2024

Pharmacy context

This is a community pharmacy in the town of Saltcoats in Ayrshire. Its main activity is dispensing NHS prescriptions. It provides a range of services including NHS Pharmacy First and NHS Pharmacy First plus. It has a delivery service, taking medicines to people in their 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	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's written procedures help team members to deliver services safely and effectively. Team members record mistakes made during the dispensing process to learn from them. And they make changes to help prevent the same mistake from happening again. They mostly keep the records required by law and they keep people's private information secure. Team members know how to respond effectively to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which helped team members manage risks to deliver services safely. They included SOPs about dispensing, the responsible pharmacist (RP), controlled drug (CD) management and NHS Pharmacy First. A sample of SOPs showed they had been reviewed at different times in the past two years by the superintendent (SI) pharmacist. Team members signed to confirm they had read them. The pharmacy had an SOP for its NHS Pharmacy First Plus service. The pharmacist accessed up-to-date information to help with their prescribing including National Institute for Clinical Excellence (NICE) guidelines.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. Each team member had their own log in which to record the details of mistakes they had made. And the RP discussed the details with the person who made the mistake. The RP reviewed the data produced from the near miss records monthly and shared the information with team members. The review captured details of the reasons why near misses may have occurred. For example, the review in August 2024 highlighted near misses involved trainee dispensers. And the action taken from this was to complete further training on the medicines involved. Information regarding the near misses was shared with the SI. Team members had suggested steps to take to help ensure the mistakes were not repeated. For example, they had placed warning labels next to look-alike and sound-alike medicines on the dispensary shelves to alert the dispenser to take extra care when selecting these medicines. The pharmacy recorded errors identified after a person had received their medicines, known as dispensing incidents. The details about the errors were captured and the information was shared with the SI who shared it as a learning event with other pharmacies in the company. Following two dispensing incidents where the wrong medicine had been handed to a person, team member's learning was to thoroughly check the prescription bag label when handing out the medicine. The pharmacist's prescribing activity for NHS Pharmacy First Plus was audited by the Health Board.

The pharmacy had current professional indemnity insurance. The accuracy checking dispensing assistant (ACDA) checked within a company protocol which meant they were able to check certain prescriptions only. These included prescriptions issued by nurses and prescriptions for multi-compartment compliance packs. The ACDA knew which prescriptions were suitable to be checked as they were stamped to show they had been clinically checked by the pharmacist. The pharmacy had a complaints policy which was given to people if necessary. Team members aimed to resolve any complaints or concerns informally. If they were unable to resolve the complaint or concern, it was escalated to the pharmacy's head office or people could use the pharmacy's website. Team members sought feedback from people via questionnaires. And feedback was shared by the RP. Team members were aware of the tasks that could and could not be completed in the absence of the RP. The RP notice was displayed in the retail area and reflected the correct details of the RP on duty. The RP record was

mostly completed correctly, with a couple of entries missing when a sample of records was checked back to August 2024. The pharmacy recorded the receipt and supply of its CDs. A sample of records showed that entries of received medicines were missing the address of the supplying wholesaler. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. Details about CD medicines returned by people who no longer needed them were recorded on receipt. And their destruction was witnessed by a registrant. The pharmacy retained certificates of conformity for unlicensed medicines known as specials. And it captured the details of who the medicine was supplied to, to provide an audit trail. The pharmacy recorded the supply of medicines against private prescriptions and records showed these were completed correctly. And associated prescriptions were retained. The pharmacy occasionally supplied people from outside Scotland with emergency supplies of their medication. Records included the reason for the supply.

Team members were aware of their responsibility to keep people's private information secure. The pharmacy had a SOP about General Data Protection Regulation. A privacy notice was displayed in the retail area informing people of how their data was used. Team members separated confidential waste which was sent to the company's head office for shredding. Team members were also aware of their responsibility to safeguard vulnerable adults and children. There was a SOP for team members to refer to if necessary. Team members confirmed they would refer any concerns to the pharmacist who would report it to the relevant authorities.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled and competent team members to help manage the workload. Team members in training receive appropriate support to complete their courses. And regular training opportunities to further develop the skills and knowledge of the qualified team members takes place. Team members suitably respond to requests for medicines and support people with their healthcare needs.

Inspector's evidence

The pharmacy employed a resident pharmacist who was the RP and a pharmacist independent prescriber (PIP). They were supported by three dispensing assistants, a dispensing assistant who was training to become a pharmacy technician and an accuracy checking dispensing assistant. The pharmacy employed additional team members who were not present during the inspection. These included a pharmacy technician, three dispensing assistants, a trainee dispensing assistant and two delivery drivers. Team members had either completed, or were in the process of completing, accredited training. The trainee pharmacy technician and trainee dispenser were supervised by the resident pharmacist and pharmacy technician respectively. The pharmacist and trainee pharmacy technician had monthly meetings to discuss the ongoing training. And trainees received protected learning time each week. Each team member had their own training folder to record training they had received. The pharmacist explained regular training days were held on public holidays when the pharmacy did not open. And a recent training day had included training about the NHS Pharmacy First service which included roleplays about potential scenarios they may encounter when delivering the service. Team members completed a training log which was kept in their training folder. The pharmacist had completed online learning modules to deliver the NHS Pharmacy First service and had completed clinical skills training to treat people accessing the NHS Pharmacy First Plus service. The PIP assessed their own competency and prescribed only for certain conditions. They were able to discuss anything they were unsure about with more experienced PIPs in the company. And if they felt they could not treat a person they referred them to another provider, such as their GP.

Team members were observed to work well together and were managing the workload. There was an open and honest culture amongst the team, and they felt comfortable discussing issues including mistakes made. And they felt comfortable to raise professional concerns with the RP or the SI if necessary. The company had a whistleblowing policy for team members if required. Annual leave was planned in advance and part-time team members or team members from other pharmacies in the company could support periods of absence. Team members had completed a competency review last year which helped identify areas where individual team members needed training. And this had been completed.

Team members knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. For example, team members highlighted to the pharmacist when a higher risk medicine, such as co-codamol, was last dispensed if the team felt it was issued too early. And for medicines that were sold repeatedly over the counter, team members had supportive conversations with people or referred to the pharmacist to refer to the person’s GP where necessary. The pharmacy did not set its team members targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and suitable for the services provided. It has appropriate facilities for people requiring privacy when accessing services.

Inspector's evidence

The pharmacy comprised of a large retail area and the main dispensary was at an elevated position behind this. The medicines counter was in front of the dispensary and acted as a barrier to the dispensary. A moveable temporary barrier had been placed at the entrance to the medicines counter to prevent unauthorised access to the medicines stored there. In the dispensary there were different benches for the completion of different tasks, including dispensing, and checking of routine prescriptions. A separate area to the rear of the dispensary was used to prepare and check multi-compartment compliance packs. The pharmacist's checking bench was situated in the dispensary so they could supervise the dispensary and medicines counter easily. There was a small hatch in the dispensary which allowed people privacy when having their medicines supervised. The dispensary had a sink which had hot and cold water. Toilet facilities and a staff area to the rear of the premises were clean and provided separate hand washing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had two lockable consultations rooms which were accessed from the dispensary for team members and from the retail area for people. Only one of the consultation rooms was used by team members for private consultations with people. The room had a desk and chairs for consultations to be completed comfortably.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages the delivery of its services safely and effectively. Team members complete suitable checks on medicines to ensure they remain fit for supply. They provide people with relevant information to help them take their medicines safely. And they respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the street which provided ease of access to those using wheelchairs or prams. Team members provided people who had visual difficulties with large print labels. And they wrote things down for people who had hearing difficulties. They had access to translation services for people whose first language was not English and displayed information about the service in the dispensary. The pharmacy displayed its opening hours and services offered in the pharmacy's front windows. And it had a range of healthcare leaflets for people to read or take away.

Team members used baskets to keep people's prescriptions and medicines together and reduce the risk of them becoming mixed up. And they used stickers to highlight the inclusion of a fridge line or CD in a prescription. For CD items, a slip highlighting the expiry date of the prescription was attached to the prescription so that team members could check it was still legally valid when people collected it. Team members signed dispensing labels so there was an audit trail to identify who was involved in which stage of the dispensing process. Team members were aware of the Pregnancy Prevention Programme for people who were prescribed valproate and the additional information to be supplied to help them take their medicine safely. The pharmacy provided valproate to people outside the manufacturer's original pack. A risk assessment for this had been completed by the person's prescriber but this was before legislation about issuing the medicine in the manufacturers original pack was in effect. Team members provided people with the warning labels about their medicines when issuing them outside the manufacturer's original pack. Team members asked appropriate questions when handing out medication to people to ensure they were provided to the correct person.

The pharmacy provided the NHS Pharmacy First service which was underpinned by patient group directions (PGDs). And the most up to date versions were accessed online. The PIP provided the NHS Pharmacy First Plus service. The PIP made records of their prescribing decisions, and provided the person's GP with a summary of the consultation and the medication provided so their GP record could be updated. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. Team members ordered the prescriptions approximately four weeks in advance so that any queries about a person's medicine could be resolved. Each person had a medication record sheet which detailed the person's medicines and administration times. Changes to a person's medication were communicated by the GP surgery or by hospital discharge and the information was recorded on the person's medication record sheet. The record detailed the changes made which included dates and the clinical check completed by the pharmacist. People were provided with descriptions of the medicines in their packs so they could be easily identified, and patient information leaflets were provided once a month. The pharmacy provided a delivery service, taking medicines to people in their homes. Team members kept a record of the deliveries to be made that day so they could answer any queries from people about their delivery. Each person had a sheet which tracked the deliveries that had been made. The sheet was taken alongside

people's deliveries, and either the person or the driver signed it to confirm the delivery had been made. Team members marked on the sheet the inclusion of a CD or fridge line. And fridge lines were placed in a cool bag to ensure they were kept cool while being transported.

The pharmacy stored its medicines neatly on the dispensary shelves. Pharmacy only (P) medicines were stored behind the medicines counter which helped ensure the sales of these medicines were supervised by the pharmacist. Team members completed checks on the expiry dates of medicines weekly. Any medicines that were going out of date in the next 12 months were highlighted with their expiry date. And medicines due to expire within six months were recorded in a folder according to the month of expiry. Team members used this record to remove medicines the month before they were due to expire. A random selection of ten medicines found none past their expiry dates. The pharmacy had a fridge to store medicines that required cold storage. Team members recorded the temperatures daily. And they recorded when action had been taken if the fridge showed a temperature out with the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via email. They printed the alerts and retained them with a record of any action taken and the team member responsible. The pharmacy kept medicines returned by people who no longer needed them separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to online resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). The pharmacist also had access to online NICE and Scottish Intercollegiate Guidelines Network (SIGN) guidelines. The pharmacy had equipment used to provide the NHS Pharmacy First Plus service including an otoscope, tongue depressors and a sphygmomanometer used to take people's blood pressure manually. It had crown marked measuring cylinders which were marked to indicate which were for water and which were for liquid medicines. The pharmacy used an automatic dispensing machine for the preparation of medicine used in the substance misuse service. And the machine was cleaned at the end of each day and calibrated each morning.

The pharmacy had portable telephones so that conversations could be kept privately. And it stored medicines awaiting collection in the dispensary in a way that ensured people's private information was secured. Confidential information was secured on computers using passwords. And they were positioned in a way that meant only authorised people could see the information on the screens. The patient medication record system was backed up daily.

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.