General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Borders Pharmacy, 8A Marmion Road, Galashiels, Scottish Borders, TD1 2DE

Pharmacy reference: 9011722

Type of pharmacy: Community

Date of inspection: 16/11/2023

Pharmacy context

This is a busy community pharmacy in the town of Galashiels in the Borders of Scotland. Its main activity is dispensing NHS prescriptions. It provides some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. And it provides a medicines delivery service for people in their homes. It supervises the administration of medicines to some people.

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 not all met	1.1	Standard not met	The pharmacy does not manage some of the key risks to patient safety. Team members do not always follow the written procedures, including for date checking and controlled drug management resulting in errors.
		1.2	Standard not met	The pharmacy makes mistakes and it does not record and report these mistakes in a timely manner to learn from them and prevent future mistakes. This includes those for some higher-risk medicines.
		1.6	Standard not met	The pharmacy does not maintain accurate records for all its higher-risk medicines. And it does not resolve problems with the accuracy of these records in a timely manner.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	Areas of the pharmacy are excessively cluttered and untidy increasing the risk of errors occurring and team members falling.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not have effective arrangements to identify and remove medicines that have expired.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not manage all the risks with its services. Team members do not always follow the written procedures increasing the risk of errors. And they do not always keep complete records as required by law. Team members do not always appropriately record and report errors, including for some higher-risk medicines. They understand their responsibilities for keeping people's personal information secure and know how to respond to concerns to help protect vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. These included controlled drug management (CD), responsible pharmacist (RP), date checking and dispensing SOPs. They had been authorised by the superintendent (SI) pharmacist in April 2023. A sample of SOPs showed that some were signed by a locum dispenser to confirm they had read them, but hadn't been signed by any other team members, including the trainee dispensers. Team members were not following some of the SOPs, for example, date checking was not completed regularly and a person had received out-of-date medication. SOPs for CD management were not being followed as errors involving CDs had not been appropriately reported.

The pharmacy recorded errors identified during the dispensing process known as near misses. Team members had recently changed the process so that the team member who made the error was responsible for recording the details of the error. They had implemented this change so that the person responsible for the error could provide the details and learn from it. Records showed that errors were being recorded, but that detail identifying the cause of the error was not always captured. This meant that opportunities to learn from the mistakes may be missed. Team members had informal conversations about the errors occurring. But they did not use the data to identify trends. Team members explained they had previously separated medicines that looked-alike and sounded-alike in response to errors, but no such changes had been identified and implemented recently. The pharmacy did not record all errors identified after a person had received their medication known as dispensing incidents in a timely manner. The pharmacy's records showed that five recent errors had been recorded, but there were several prescriptions where errors had been identified that were stored in baskets in the dispensary waiting to be recorded. This included errors involving out-of-date medication, an incorrect strength of medication given to a person, and an incorrect medicine supplied, which was a controlled drug. The pharmacy hadn't reported errors involving controlled drugs to the Health Board's Controlled Drug Accountable Officer (CDAO). During the inspection, a person returned a medicine that had been issued in error. The pharmacy technician kept the medicine aside for reporting later.

Team members explained they had been provided with their job descriptions upon offer of employment, which set out their role. They were directed to the daily tasks they were responsible for by the pharmacy technician. The RP notice was prominently displayed, and team members knew what they could and could not do in the absence of the RP. Team members explained complaints were usually resolved at a local level, and if necessary they escalated unresolved complaints to the pharmacy's head office. Team members provided people with these details and the information was available on the pharmacy's website. There was current professional indemnity insurance.

The pharmacy had controlled drug registers but not all entries were completed accurately and there

were discrepancies that had not been reported to the CDAO. The entries checked contained the information required by law. And CDs returned by people who no longer needed them were recorded. The locum pharmacist had implemented a procedure for keeping all CD prescriptions together in a basket to help ensure CD records were made in a timely manner and to avoid missed entries. The pharmacy dispensed few private prescriptions and not all of these were seen to be entered into the private prescription register. This included two examples seen from July 2023. The pharmacy held records for the supply of unlicensed medicines known as "specials". Not all were complete, with the last six missing the details of who received the supply. The pharmacy's RP records captured the details of when the RP commenced responsibility but did not always capture the details of when they ceased being the RP.

Pharmacy team members were aware of the importance of keeping people's private information safe, although they had received no formal training about information governance (IG) and the General Data Protection Regulation (GDPR). Delivery drivers kept people's private information secure when delivering medicines to people in their homes. Team members shredded confidential waste using a small shredder, which meant that sometimes there was confidential waste awaiting destruction. The pharmacist confirmed he had completed safeguarding training but was unsure of when this was. Team members explained if they had any concerns for a potentially vulnerable person, they would report these to the pharmacist. And the pharmacist confirmed they would take the necessary action. Team members could access local safeguarding contacts online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members who have, or are learning, appropriate knowledge and skills to provide services. And they support each other to learn. Team members work well together and feel comfortable to raise concerns with management.

Inspector's evidence

The pharmacy team at the time of the inspection included a locum pharmacist, who was the RP, a pharmacy technician and two trainee dispensers. The team further comprised of three delivery drivers, two trained dispensers and a locum dispenser who were not present. The trainee dispensers had been given some initial training in their roles by the pharmacy technician. And there was a plan to enrol them on accredited training. Team members were seen to be working well together. The pharmacy had experienced an increase in workload and as a result, team members were focussing on dispensing and checking prescriptions. They were under some pressure to complete administrative tasks in a timely manner. This included reporting errors in a timely manner and ensuring regular checks of the suitability of medicines to be supplied were completed. They reported sometimes feeling stressed with the overall workload. Part-time team members and team members from the company's other pharmacy could cover absences where required. Delivery drivers described working more hours than they were contracted for.

The pharmacy was co-located with a post office and the medicines counter also acted as a counter for the post office. There were three team members employed to work for the post office. The SI gave assurances that untrained team members were not involved in the sale of medicines and referred these requests to the RP.

The pharmacist had previously completed training for the provision of services such as treatment of urinary tract infections and emergency hormonal contraception. And they assisted with the development of the trainee dispensers. Team members did not receive any regular ongoing training opportunities to help them develop. They supported each other with queries and learning. Targets were not set by the pharmacy. Team members reported feeling comfortable to raise concerns with the management team and SI, but they felt some issues were not always resolved in a timely manner.

Principle 3 - Premises **Standards not all met**

Summary findings

Some areas of the pharmacy are excessively cluttered and untidy. This increases the risk of errors and of team members falling. It has soundproofed rooms where people can have private conversations with team members. But not all are tidy and portray a professional image.

Inspector's evidence

The pharmacy had a retail area to the front and a large dispensary to the rear of the premises. The retail area was tidy and reflected a professional appearance. The dispensary was cluttered and untidy. There was a significant volume of clutter on the dispensary floor which created a hazard of trips or falls. There were different bench spaces for the completion of different tasks. However, these were also cluttered, and medicines were stored untidily on shelves which increased the risk of errors occurring. The pharmacy's website had not been updated to reflect the new premises address.

There were two soundproofed rooms where people could have private conversations with team members and access services from the pharmacist. The larger consultation room did not reflect a professional appearance as team members used it to store excess retail stock. This reduced the size of available space for the pharmacist to consult effectively. The room had no chairs for either the pharmacist or for people accessing services to use.

The pharmacy had a sink in the dispensary which was used for the preparation of medicines and provided hot and cold water. Toilet facilities were clean and had facilities for hand washing. The pharmacy stored medicines returned by people who no longer needed them in sealed bags in the toilet awaiting collection by a third-party company. The medicines counter acted as a barrier to restrict unauthorised public access to the dispensary. And the pharmacist's checking bench was situated so that they could intervene in conversations at the medicines counter if necessary. The temperature was comfortable throughout and the lighting was bright.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not always suitably manage its medicines. Team members do not follow a robust process for checking expiry dates of medicines. So, people may take medicines that are not fit for purpose. Team members generally provide pharmacy services safely. And they follow processes to help make sure people receive their medicines when they need them.

Inspector's evidence

The pharmacy had a step-free entrance. It advertised a range of services, some of which it did not provide, such as vaccinations which may be confusing for people. It provided some people who had visual difficulties with large print labels.

The pharmacy provided a delivery service, taking medicines to people in their homes. Multi-compartment compliance packs were packed into boxes ready for delivery up to two weeks in advance. They were stored on a bench in the dispensary which reduced space. Delivery drivers used lists with people's names and addresses on for the deliveries. The lists were highlighted with stickers if there was a fridge line or controlled drug to be included with the delivery. During the inspection, team members discovered a medicine that had been returned by the driver as a failed delivery. The medicine required storage in the fridge but had been returned to the delivery shelves. This was highlighted to the RP to resolve. The pharmacy had an agreement with some people that their deliveries could be left if they were not available to receive them. Team members documented some of these requests on the patient's PMR with one example seen showed where the delivery was to be left. Although there were no reported issues, the pharmacy did not have a process to regularly review these arrangements to ensure they remained appropriate.

The pharmacy used baskets to keep people's prescriptions and their medicines together to reduce the risk of errors occurring. Team members used stickers as part of their dispensing process to highlight if a fridge line, controlled drug, or intervention by the pharmacist was required. Team members signed dispensing labels to indicate who had dispensed a medication and who had checked it, so team members involved in each stage could be identified. The pharmacy dispensed and supervised the administration of medicine for some people. Team members prepared doses in advance to help manage the workload. The pharmacist was aware of their additional responsibility when clinically checking higher-risk medicines including valproate and knew that additional counselling was required for these people. But counselling and checks were not always being completed. The pharmacy had approximately twenty people taking valproate in the at-risk category. They knew to issue people with patient cards but not all team members were aware of recent updated guidance for issuing valproate in its original pack.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines. Team members ordered prescriptions in advance of packs being dispensed so any queries could be resolved before people needed their medicines. They received communication about changes to people's packs from the doctor's surgery. The pharmacy held a record of each person's medicines and when they took them. The pharmacy had considered the risks of putting medicines with limited stability into multi-compartment compliance packs. These were dispensed into the packs on the day they were due or were supplied separately out with the packs. This included for

valproate and discussions were had about the updated guidance. Team members did not always provide descriptions of medicines in the packs, so people may struggle to identify the medicines. They provided people with patient information leaflets (PILs), so they had the information to take their medicines.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only medicines were stored behind the medicines counter which ensured sales of these medicines were supervised by the pharmacist. The pharmacy did not complete regular date checking of its medicines as per the SOP and there were out-of-date medicines on the shelves. A random sample of approximately twenty medicines checked found three out-of-date medicines with one medicine due to expire at the end of the month. Team members explained they checked expiry dates when dispensing and checking medication but there was an example of a dispensing incident where a person had received an out-of-date medicine. Team members recorded fridge temperatures daily and these were within range. They received information regarding drug alerts and recalls, printed them off and stored them in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for its services. And it mostly ensures the facilities are used in a way that protects people’s private information.

Inspector's evidence

The pharmacy had access to reference resources such as paper copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). And it had crown stamped measuring cylinders that were used for measuring water and liquid medicines. These were kept seperately. It had destruction kits used to destroy out of date and patient returned controlled drugs.

Access to the computer system was password protected and screens were positioned within the dispensary, so they were not visible to unauthorised people. Team members used a cordless telephone to ensure telephone calls were kept private. The pharmacy stored prescriptions and medicines awaiting collection adjacent to the medicines counter on shelves. The shelves mostly helped protect people's private information although a couple of bags were at a higher level than the shelves.

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.