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: 03/07/2024

Pharmacy context

This is a busy community pharmacy in the town of Galashiels in the Scottish Borders. Its main activity is dispensing NHS prescriptions. It provides some people with their medication in multi-compartment compliance packs to help them take their medicines correctly and it provides a range of NHS services including Pharmacy First. 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 manage risk and provide services safely. 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 generally keep the records required by law and keep people's private information secure. Team members have completed training to respond appropriately to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. Team members signed competency records to confirm they had read and understood the SOPs. And they had read the SOPs and completed their declarations in the last six months. The SOPs were not dated to indicate when they were first issued or due a review, but the pharmacy manager confirmed they had been issued directly from the superintendent pharmacist (SI) in January 2024. And the SOPs were being reviewed by the company's management team.

The pharmacy recorded mistakes identified and resolved during the dispensing process known as near misses. The team member who corrected the mistake recorded the details about it when identified by the pharmacist. This was to ensure details of mistakes were recorded if the team member who made the mistake was not working when it was identified. The pharmacy manager discussed the mistake with the person who made it to establish any learnings. And the pharmacy manager completed a monthly review of the mistakes made to help identify trends and recorded actions taken to help prevent the mistake from occurring again. This included separating medicines that looked-alike and sounded-alike from each other on the shelves where they were kept and giving additional support to trainees to help them double check the medication they had dispensed. The pharmacy completed incident reports for errors that were identified after a person had received their medicines known as dispensing errors. These were recorded electronically, and the pharmacy manager telephoned the area manager to inform them of dispensing errors.

The pharmacy's website had details of how a person could raise a concern directly with the company's head office. Team members aimed to resolve complaints or concerns informally with people. For any complaints that could not be resolved, team members escalated the details to the company's head office. The pharmacy had professional indemnity insurance. Team members were observed working within the scope of their roles. The accuracy checking pharmacy technician (ACPT) had discussed with the area manager which prescriptions they felt comfortable checking, and this did not include schedule 2 controlled drugs (CDs). And the ACPT had discussions with every pharmacist working in the pharmacy to ensure they were comfortable for the ACPT to complete accuracy checks. Team members were aware of the activities that could and could not take place in the absence of the responsible pharmacist (RP). The RP notice was prominently displayed in the retail area and reflected the details of the RP on duty. The RP record was mostly completed correctly, with some minor omissions of the time the RP ceased duty. The pharmacy recorded the receipt and supply of its CDs electronically. The entries checked were in order. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy recorded details of CD medicines returned by people who no longer needed them at the point of receipt. The destruction of these was completed and witnessed by the pharmacist and ACPT respectively and had been completed recently. The pharmacy

kept certificates of conformity for unlicensed medicines and details of who the medicine was supplied to, which provided an audit trail. It kept paper-based records for its supply of medicines against private prescriptions. The records were completed with most of the required details but did not capture the date on the prescription. The pharmacy kept the associated private prescriptions.

The pharmacy displayed an NHS data processing notice in the retail area which informed people of how their data was used. Team members understood their responsibility to keep people's private information secure and had read and understood the SOP related to this. Trainee dispensers also received additional training on information governance and General Data Protection Regulation as part of their accredited qualification training. The pharmacy separated confidential waste for destruction. Team members were aware of their responsibility to safeguard vulnerable adults and children. They knew to refer any concerns to the pharmacist or pharmacy manager in the first instance. Some team members, including the pharmacist and ACPT, were registered with the protecting vulnerable groups scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and competent team members to help manage the workload. And those in training receive appropriate supervision. Team members complete ongoing training to help develop their skills and knowledge. They suitably respond to requests for advice and sales of medicines.

Inspector's evidence

The RP at the time of the inspection was a locum, who had been working regularly in the pharmacy over the past few months. They were supported by an ACPT, who was also the pharmacy manager, a relief dispenser, and three additional dispensers. The pharmacy also employed a dispenser and two trainee dispensers who were not present during the inspection. And there were two delivery drivers. The pharmacy was co-located with a post office, with one of the post office team members having completed medicines counter assistant training. Other post office team members did not sell medicines. A new team member had started employment a week before the inspection. The pharmacy manager confirmed they were to be enrolled on accredited qualification training within three months and after the completion of an induction period. Other team members had either completed or were in the process of completing accredited qualification training for their roles. The ACPT acted as tutor for the trainees and both trainees were due to complete their training soon. All team members received half an hour protected training time each week. And they identified their own knowledge gaps and completed learning to help develop their skills and knowledge relevant to this. For example, one team member had recently reviewed their knowledge of over-the-counter medicines. The pharmacist had completed training and read patient group directions (PGDs) to provide the NHS Pharmacy First service.

Team members were observed to work well together and were managing the workload. They communicated well with each other and assisted each other with queries. Annual leave was planned in advance so that contingency arrangements could be made. Part-time team members could increase their hours or relief dispensers from within the company could be utilised to support periods of absence. And the pharmacy manager had planned rotas for the workload to ensure team members knew when certain tasks were due to be completed. Team members had been trained to complete all dispensing activities so there was continuity during absences. There was an open and honest culture amongst the team and team members felt able to raise professional concerns with the pharmacy manager or area manager if necessary. Newly employed team members who had gone through an induction period received performance reviews from the pharmacy manager.

Team members asked appropriate questions when selling medicines over the counter and referred to the pharmacist if necessary. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They would highlight any instances of repeated requests to each other and would refer such requests to the ACPT, pharmacist or the person’s GP. The pharmacy did not set its team members targets, but this was being reviewed by the company’s management team.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises comprised of a spacious retail area and large dispensary. The retail area had seating for people who wished to wait while their prescriptions were prepared. There was a medicines counter which was clean and tidy, portraying a professional appearance. The medicines counter was situated directly in front of the dispensary and there was a barrier to prevent unauthorised access to the medicines counter and dispensary. Team members kept the dispensary clean and free from clutter. There was an organised workflow and different benches were used for different tasks, including a separate area used to prepare multi-compartment compliance packs and deliveries. The pharmacist's checking bench was positioned in the dispensary so they could supervise the dispensary easily and intervene in conversations at the medicines counter if necessary. The dispensary had a sink which provided hot and cold water. The pharmacy had toilet facilities and a room where team members could have their breaks which were clean and had separate handwashing facilities. Lighting provided good visibility throughout and the temperature was comfortable. Team members cleaned the dispensary weekly.

The pharmacy had two soundproofed consultation rooms which allowed people to have private conversations and access services. The main consultation room had a desk with two chairs for consultations to be completed comfortably. The second smaller room was used for the supervision of medicines via a hatch into the dispensary. Both consultation rooms were clean and tidy and had sinks which provided hot and cold water.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. Team members source medicines from recognised suppliers and complete checks on them to ensure they are fit for supply. They provide people accessing services 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 and double doors to provide ease of access to those using wheelchairs or with prams. Team members provided some people with visual difficulties with large print labels. And they gave information in writing for people who had hearing difficulties. The pharmacy's services such as NHS Pharmacy First were underpinned by PGDs which the pharmacist had signed. And they accessed the most up-to-date versions online.

Team members used baskets to keep people's prescriptions and medicines together to reduce the risk of errors. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members used stickers to highlight the inclusion of a fridge line or CD. They were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. They were aware of updated legislation for providing valproate in manufacturer's original containers. And for those who received their valproate in multi-compartment compliance packs, a risk assessment had been completed by other healthcare professionals involved in their care. Team members were observed asking appropriate questions when handing out medicines to ensure they were provided to the correct person. They provided people with an owing slip, which was record of the medicines they could not provide the full quantity of. Team members checked prescriptions with owed medication twice daily. And they used a Health Board issued form to request an alternative medicine from the person's GP if the medicine was out of stock.

The pharmacy supervised the administration of medicine for some people. The ACPT prepared the medicine in advance, so it was ready for people to collect. And the pharmacist checked the accuracy of the volumes poured. The pharmacy had a delivery service, taking medicines to people in their homes. Team members made a record of the deliveries to be made each day which the driver used to organise their workload. And the record was left in the pharmacy so team members could answer queries from people about their deliveries. The drivers asked people to sign to confirm receipt of their CDs. Any failed deliveries were returned to the pharmacy and a note of the attempted delivery was left.

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 prescriptions in advance of them being required so that any queries could be resolved in a timely manner. Each person had a medication record sheet which detailed the medicines and administration times. Any changes were communicated by telephone or email from the GP surgery. And the pharmacy kept a medication change form as a written record of the change. Team members initialled the medication change form to confirm the change had been completed. Sheets attached to the pack provided a record of the medicines in the pack and included written descriptions of the medicines so they could be easily identified. Team members provided patient information leaflets once a month so people could read

about the medicines they were taking.

The pharmacy sourced its medicines from licensed wholesalers. Medicines were stored neatly on the dispensary shelves. Pharmacy only (P) medicines were stored behind the medicines counter which ensured sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. And records showed they had completed date checking up to the middle of August. Medicines expiring in the next six months were highlighted for use first. And liquid medicines with a shortened expiry date on opening were marked with the date of opening. A random check of medicines found one expired medicine which was removed during the inspection. Team members checked the expiry date of medicines as they dispensed and checked prescriptions. The pharmacy had a fridge to store medicines that required cold storage. And records showed the fridge was generally operating between the required two and eight degrees Celsius. Occasionally the temperature recorded was above eight degrees and team members recorded the action taken to resolve this. Team members received notifications about drug alerts and recalls via email. They took action and retained the alerts for future reference. The pharmacy kept medicines returned by people who no longer needed them in pharmaceutical waste containers in the dispensary for secure destruction by a third party.

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 electronic reference resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had ISO marked measuring cylinders which were kept in separate areas of the dispensary to indicate which were for water and which were for liquid medicines. It had clean triangles used to count tablets and clean capsule counters.

The pharmacy had cordless telephones so that conversations could be kept private. And it stored medicines awaiting collection in a way that ensured people's private information was secured. Confidential information was secured on computers using passwords. And they were positioned within the dispensary which meant that only authorised people could see them.

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.