General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Guide Pharmacy Annan, 49 Rose Street, ANNAN, Dumfriesshire, DG12 5AS

Pharmacy reference: 1041999

Type of pharmacy: Community

Date of inspection: 11/01/2024

Pharmacy context

This is a community pharmacy in the town of Annan in the south-west 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. The pharmacy had recently changed ownership.

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 manage risk so its team members can provide services safely. Team members record errors made during the dispensing process so they can learn from them. They keep records required by law and keep people's private information secure. They know how to respond effectively to concerns for people accessing the pharmacy's services.

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) and dispensing SOPs. The SOPs had been recently introduced by the new owner and were provided in paper format for team members to refer to. A sample of SOPs seen showed that all team members except the RP had signed them to confirm their understanding of them.

The pharmacy recorded errors identified by the pharmacist during the dispensing process known as near misses. The team member who made the error was responsible for recording the details so they could 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 mistake may be missed. Team members did not formally review the data to identify trends, but the pharmacist had identified repeated errors involving labelling of prescriptions. Team members had informal conversations regarding these errors, and they reviewed their procedure for labelling, which had resulted in fewer near misses being made. They knew to record errors identified after a person had received their medication known as dispensing incidents. But they had not had any such incidents since the pharmacy changed ownership and were not familiar with the pharmacy's procedure for reporting these errors. The pharmacist explained they would contact the owners for assistance should the need arise. Team members aimed to resolve any concerns or complaints informally. If they were not able to resolve any complaints informally, they would escalate these to the owner or superintendent pharmacist (SI). The pharmacy encouraged people to provide feedback and make suggestions for improvements. Team members had received feedback that a newly installed access ramp for those with limited mobility was too steep and this had been passed to the owners for review.

The pharmacy had current indemnity insurance. Team members were observed working within the scope of their roles. And they knew which tasks could and could not be completed in the absence of the RP. The RP record was compliant. The pharmacy had an electronic CD register and the entries checked were in order. Team members checked the physical stock levels of tablets and capsules matched with those in the CD register on a weekly basis. But physical stock level checks of medicine used in the supervision service were completed less frequently, with the last check completed in October 2023. The pharmacy recorded details of CD medicines returned by people who no longer needed them. It kept certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. It kept paper records for its supply of private prescriptions, and these were mainly compliant, although occasionally the date of the prescription had not been recorded.

The pharmacy had a privacy notice in the consultation room informing people of how the pharmacy used their data. Team members had received training regarding information governance (IG) and general data protection regulations (GDPR) in the form of SOPs under the new ownership. And they

were observed separating confidential waste for collection for destruction by a third-party company. The pharmacy stored confidential information in staff-only areas. Team members had completed safeguarding training as part of their previous employment and knew to refer any concerns to the RP. The delivery driver was also aware of his responsibilities to report any concerns whilst delivering medicines. Team members had access to contact details for relevant local authorities. The pharmacist was part of the protecting vulnerable groups (PVG) scheme and was disclosure and barring service (DBS) checked.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and qualified team members to help manage the workload. Team members support each other with ongoing learning. There is an open and honest culture amongst the team. And they know how to suitably respond to repeated requests for medicines liable to misuse.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was the RP during the inspection. Other team members included a dispenser, who was also the manager, two further dispensers and a delivery driver. Some team members had recently completed accredited training for their roles and certificates confirming their qualifications were available. They had not yet received any ongoing learning with the new owners, but supported each other with learnings, including queries about medicines. And they periodically received pharmacy-based magazines which they could read to develop their knowledge. The pharmacist had completed training to provide the NHS Pharmacy First service and had signed associated patient group directions (PGDs) to confirm they would comply with them. And they confirmed they had shared a signed declaration of competency with the Health Board.

Team members were seen to be working well together to manage the workload. Annual leave was planned in advance so workload could be managed to cover team members holidays. Team members rotated tasks so there was contingency for absences. And part-time team members increased their hours to provide support during periods of absence. The pharmacy recently had two dispensers leave their positions. Team members confirmed the new owner was planning to replace one of the positions. And they were able to contact the owner to arrange for locum dispensers to assist if needed. There was an open and honest culture amongst the team and team members reported feeling comfortable to raise concerns or make suggestions for change with management.

Team members asked appropriate questions when selling medicines over the counter and they were observed asking additional information such as if a person had an antibiotic allergy. They knew to be vigilant to repeated requests for medicines liable to misuse and referred these to the pharmacist, who had conversations to help people and referred them to their GP if necessary. The pharmacy had not yet set its team members targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. And team members ensure the dispensary remains clean, especially during an ongoing refit. The pharmacy has a suitable consultation room where people can have private conversations with team members.

Inspector's evidence

The premises were comprised of a retail area to the front and a dispensary at the rear. The pharmacy had recently changed ownership and was undergoing a refit in the retail area to make better use of the space. Due to this, there was currently no pharmacy signage on the outside of the building identifying the pharmacy. The pharmacy had a medicines counter which acted as a barrier to the dispensary and prevented unauthorised access. The dispensary was neat and tidy and portrayed a professional appearance. And it was clean despite the ongoing refit. It was comprised of two separate dispensary areas, one to the front and one to the back. There was a good workflow and team members had recently changed their ways of working by ensuring that all dispensing activity was completed in the back dispensary and only checking of prescriptions was completed in the front dispensary by the pharmacist. The pharmacist reported that previously both dispensing activity and checking of prescriptions was completed in the front dispensary which increased the risk of distractions. The pharmacist's checking bench was positioned so they could intervene in conversations at the medicines counter if necessary. The dispensary had a sink which was clean and tidy. And it provided hot and cold water for handwashing. Toilet facilities were clean and had facilities for hand washing. Lighting was bright throughout but the temperature was cold due to the ongoing refit, despite there being a heating system. Team members had been provided with additional heaters and reported being able to ask for more if needed.

The pharmacy had a newly refurbished and soundproofed consultation room completed as part of the ongoing works. It allowed people to have private conversations and access services. There was a desk and two chairs for consultations to be completed comfortably. And there was a sink with hot and cold water. The room was not lockable, but it was positioned within sight of the medicines counter so team members would be alert to unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. Team members carry out checks to ensure that medicines remain fit for supply and know how to respond to alerts that medicines might not be suitable to supply. They provide people with the necessary information to take their medicines safely and effectively. And they source their medicines from licensed wholesalers.

Inspector's evidence

The pharmacy had recently upgraded access to the pharmacy by installing an automatic door. And work was ongoing to provide a suitable ramp for ease of access to those using wheelchairs or prams. The pharmacy had some leaflets for people to read or take away, which included information on the NHS Pharmacy First Service. The pharmacy provided a range of services including the NHS Pharmacy First service and supervision of medicines for some people.

Team members used baskets to keep people's prescriptions and medicines together and reduce the risk of errors. They used stickers to highlight the inclusion of a fridge line or CD on a prescription. And prescriptions were highlighted for referral to the pharmacist when being handed out if needed. This usually involved higher-risk medicines or if the pharmacist needed to provide additional counselling to people about their medicines. Team members signed to confirm who had dispensed a medicine and who had checked it so there was a full audit trail of those involved in each stage. The pharmacy supplied people with an owing slip when they could not provide the full quantity of medicine prescribed. The pharmacy provided a delivery service, taking medicines to people in their homes. The driver asked people to sign to confirm receipt of their CDs. Records of deliveries were kept so that any queries could be resolved. And medicines that required cold storage were delivered as a priority. The pharmacy supervised the administration of medicine to some people. Team members managed the service by using an automated machine to measure the volume of the medicine. And they used this machine on days where there were many doses to be prepared. For other days which did not require the use of the automated machine, team members poured and measured the doses by hand.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines. Each person had a medication record sheet that contained a copy of the medicines and dosage times. And any changes received from the person's GP were documented on the record. Team members were responsible for ordering prescriptions, and this was completed ahead of them being required so that any queries could be resolved in a timely manner. Team members provided descriptions of the medicines in the packs so they could be easily identified. And they provided people with the necessary information to take their medicines effectively, including warnings and patient information leaflets (PILs).

Team members were aware of the requirements of the Pregnancy Prevention Programme (PPP) for people who were dispensed valproate and were aware that these people required additional information to take their medicines safely. They confirmed they did not currently have any patients in the at-risk category. Team members were aware of the updated guidance for dispensing valproate into original packs and confirmed that people who had their medicines dispensed into multi-compartment compliance packs had valproate issued in the original packs.

The pharmacy sourced its medicines from licensed wholesalers, and it kept medicines in original containers. Team members checked the expiry dates of medicines. They reported date checking the entire dispensary two weeks prior to the inspection. However, they had no records confirming this. Team members had previous date checking records which showed that date checking was being completed regularly. And random sampling of 15 medicines found no out-of-date medicines. The pharmacy had a medical grade fridge for medicines that required cold storage. Team members recorded the temperatures daily. They had quarantined and subsequently disposed of stock kept in the fridge upon discovering that the medicines may not have been stored at the required temperatures while the pharmacy was closed. They received notifications about drug alerts and recalls via emails which they printed, actioned and stored for future reference. Medicines returned by people who no longer needed them were kept 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 up-to-date reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had clean BS and ISO stamped measuring cylinders which were marked to identify which were for water and which were for medicines. And there were clean triangles used for counting tablets. The pharmacy had an automated machine used to measure volumes of substance misuse medicines which was cleaned when it was in use. The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines waiting collection so that people could not see people's private information. Confidential information was secured on computers using passwords. Computer screens were positioned within the dispensary so 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.