General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: A & A Gilbride Ltd., 170 Carmyle Avenue, Carmyle, GLASGOW, Lanarkshire, G32 8EE

Pharmacy reference: 1042312

Type of pharmacy: Community

Date of inspection: 23/05/2024

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via patient group directions (PGDs).

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 team members work to professional standards to keep services safe and effective. They discuss mistakes that happen when dispensing. And they keep records to identify patterns in the mistakes and reduce the risk of errors. The pharmacy keeps the records it needs to by law, but it does not always securely dispose of information. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The pharmacy defined the pharmacy's working practices in a range of relevant standard operating procedures (SOPs) and they were readily available for team members to access whenever they needed to. A new pharmacist had taken up post in April 2024. They had printed copies of SOPs that had been recently updated and they had instructed team members to read and sign them to confirm their understanding. The pharmacist monitored ongoing compliance with SOPs and provided extra support when improvement was needed. A signature audit trail on medicine labels showed who was responsible for dispensing each prescription.

The pharmacist was able to identify and help team members learn from their dispensing mistakes. This included recording and monitoring errors identified before they reached people, known as near miss errors. Team members recorded their own near miss errors in a designated book. And the pharmacist transcribed the information to an electronic record at the end of the week. They analysed the information to identify patterns and trends which they discussed with team members to make safety improvements and to manage the risk of recurrence. Team members provided examples of improvements, such as stocking only 200 dose glyceryl trinitrate sprays to manage the risk of mix ups with the 180-dose sprays which they had stopped supplying. They also sometimes asked colleagues for an extra check before the final accuracy check. This helped to prevent selection errors they had made in the past. For example, checks to make sure they selected the correct strength of topiramate and to avoid mix-ups with the 200mg and 5mg strength.

Team members knew how to manage complaints and knew to escalate dispensing mistakes that people reported after they left the pharmacy. The pharmacist discussed the incidents with team members, so they learned how to manage risks to keep dispensing safe.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice which was visible from the waiting area and the RP record was up to date. Team members maintained controlled drug (CD) registers and they checked and verified the balances twice a month. The pharmacy kept electronic records of CDs that people returned for disposal. Team members filed prescriptions so they could easily retrieve them if needed and they kept records of supplies of unlicensed medicines and private prescriptions that were up to date.

The pharmacy protected people's privacy and a shredder was available to safely dispose of confidential waste. But it had stopped working at the beginning of April 2024 and had not been replaced which caused a security risk. Team members were tearing labels into small pieces and ensured people's details were obscured before placing them in the general waste for disposal.

The pharmacy trained its team members to identify vulnerable adults and children and they knew to discuss safeguarding concerns with the pharmacist to protect them. For example, when some people did not collect their medication on time, and when the driver was unable to complete deliveries that had been previously arranged.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy supports team members to learn and develop.

Inspector's evidence

The pharmacy regularly reviewed its staffing levels and skill mix arrangements and made improvements when there were shortfalls. The new superintendent pharmacist (SI) who had recently taken up post had arranged for a new pharmacy student to work at the pharmacy due after previous students left. The new team member was scheduled to work every Saturday and to provide backfill when colleagues were on leave. The following team members were in post; a regular full-time pharmacist, one full-time trainee dispenser, one part-time dispenser and one part-time delivery driver. The pharmacy had minimum staffing levels in place with only one team member permitted to take leave at the one time. The part-time dispenser increased their hours to provide cover when necessary, and this helped with the pharmacy's service continuity arrangements. The pharmacy had an informal induction arrangement in place for new team members and the trainee dispenser had been supported by the pharmacist and other colleagues when they took up their post. They had been instructed to read some of the pharmacy's SOPs before carrying out tasks on their own. And they had learned about data protection and safeguarding vulnerable people arrangements so they could refer concerns to the pharmacist.

The pharmacy enrolled new team members onto qualification training within the required timescales and the pharmacist provided protected learning time in the workplace. This ensured they were supported in their studies and made satisfactory progress. The company encouraged and supported experienced team members to enrol on qualification training. This included pharmacy technician and pharmacist independent prescribing training. The pharmacist ensured team members kept up to date in their roles and responsibilities. They discussed near miss errors to identify and implement safety improvements. They also discussed new initiatives and service changes such as those required by the health board. For example, team members knew to supply Lufrobec inhalers instead of Fostair inhalers in line with the local formulary, and they knew to refer people to the pharmacist to answer any queries about the changes. Team members had completed the necessary training to provide some of the pharmacy's services. This included smoking cessation training which they were authorised to provide. Team members had been trained to provide the appropriate advice when making sales of pharmacy only (P) medicines. For example, when people requested codeine-containing medicines they knew to refer to the pharmacist when people made excessive requests.

The pharmacy trained team members so they understood their obligations to raise whistleblowing concerns. This ensured they knew when to refer concerns to the pharmacist or another team member. The pharmacy encouraged team members to provide feedback and to make suggestions for improvements to keep services safe and effective. Following a refurbishment at the pharmacy in October 2023, the pharmacist owner empowered team members to organise the new pharmacy to meet the needs of the service. Team members continued to refine the new arrangements, for example, they were in the process of reviewing the stocks of dressings and bandages to better meet prescription

requirements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has adequate facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The pharmacy had been refurbished in October 2023. It was a modern, purpose-built premises, and it presented a professional image to the people that used it. Team members managed the available workspace well to ensure dispensing procedures were conducted safely and effectively. They used designated workstations according to the tasks they performed. This included a separate area for the pharmacist who had good visibility of the medicines counter and could intervene when necessary. It also included a separate rear bench that was used to assemble and label multi-compartment compliance packs. This ensured there was sufficient space for the prescriptions and the relevant documentation to keep dispensing safe.

The pharmacy had a separate, well-equipped consultation room with hot and cold running water. It provided an environment for people to speak freely with the pharmacist and other team members during private consultations. There were two clean, well-maintained sinks in the dispensary that were used for medicines preparation. And team members cleaned and sanitised all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout. And the ambient temperature provided a suitable environment to store medicines and to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services safely. The pharmacy gets its medicines from reputable sources. It generally stores its medicines appropriately, but some medicines are stored without all the information they should have.

Inspector's evidence

The pharmacy provided access via a level entrance which helped people with mobility difficulties. A range of patient information leaflets helped people understand some health conditions and available treatments. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were fit for purpose. These included checks of expiry dates which they documented to show when checks were next due. Team members had last carried out checks in December 2023. But this meant they were behind with the checks which required to be undertaken once a month. The pharmacy used two fridges to keep medicines at the manufacturers' recommended temperature. And team members read and recorded the temperature every day to show that fridges operated within the accepted range of between two and eight degrees Celsius. The fridges were organised with items safely segregated which helped team members manage the risk of selection errors. They used clear bags for items they had previously dispensed and awaited collection. This made retrieval easier and helped with the necessary safety checks that were required before making a supply. Team members used two secure cabinets for some of its items and medicines were organised with segregated items awaiting destruction.

The pharmacy received drug alerts and recall notifications. Team members checked the notifications and acted on them when necessary. They kept audit trails to confirm they had conducted the necessary checks which included removing affected items and isolating them from stock. The pharmacy had medical waste bins to support the team in managing pharmaceutical waste. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant information. They also knew about recent legislative changes which required them to provide supplies in the original manufacturer's pack unless in exceptional circumstances.

The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members manage the risk of items becoming mixed-up. The pharmacy supplied some people with multi-compartment compliance packs to help them with their medicines They also provided descriptions of medicines and supplied patient information leaflets (PILs). Team members used supplementary records to carry out the necessary checks. This helped to confirm people’s prescription requirements and to identify any changes which they queried with the surgery. Team members had removed medicines from multi-compartment compliance packs that had not left the pharmacy and were no longer needed. At the time of the inspection several clear bags were on a dispensing bench for re-use. But the bags had not been labelled with relevant information such as expiry date and batch number of the medicine. So team members could not carry out the necessary checks to ensure that medication was fit for purpose. The inspector provided team members with advice and they disposed of the medicines at the time of the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse medicines. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could conduct conversations in private if needed, using portable telephone handsets. The pharmacy used a new blood pressure machine, but they had not considered the need for recalibrations and there was no record of when it had been first used.

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.