General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Guidi's Pharmacy, 139 Thurston Road, Hillington, GLASGOW, Lanarkshire, G52 2AZ

Pharmacy reference: 1042512

Type of pharmacy: Community

Date of inspection: 20/03/2024

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, and it protects confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people.

Inspector's evidence

The pharmacist owner had removed the pharmacy's standard operating procedures (SOPs) and was updating them to reflect the pharmacy's working practices. The pharmacist manager contacted the owner following the inspection visit and provided evidence that SOPs had been updated and in the process of being implemented. Team members signed the SOPs to confirm they had read and understood them, and the pharmacist manager monitored compliance to ensure the pharmacy was operating safely and effectively. The pharmacy employed accuracy checking pharmacy technicians (ACPT), and it was about to enrol a dispense on the accuracy in dispensing course. A SOP had been developed and implemented for them to follow when carrying out the necessary accuracy checks. This included only carrying out accuracy checks on prescriptions that had been clinically checked and annotated by a pharmacist. A signature audit trail on the medicine labels showed who was responsible for dispensing each prescription. This meant the pharmacists and the ACPTs were able to identify and help team members learn from their dispensing mistakes. The pharmacists and the ACPTs kept records of errors and monitored them to identify any patterns or trends. They discussed them with the rest of the pharmacy team and agreed actions to manage dispensing risks. This included applying the pharmacy's warning labels to shelves to 'check strength', check formulation' and 'check drug' when stock was affected. This had included the different strengths of diazepam and similar packs of ferrous sulphate and ferrous fumarate.

The pharmacy displayed notices and encouraged people to discuss concerns or to provide comments and suggestions. Team members knew how to manage complaints and discussed them in private in the consultation room when necessary. They also knew how to manage dispensing mistakes that people reported after they left the pharmacy. The pharmacist completed an incident report following an investigation and included information about the root cause and any necessary improvements they had made. They shared significant incidents with the SI to make sure they were aware.

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 mostly up to date. But there were some missing entries to show the time the pharmacist had finished their duties for the day. Team members maintained controlled drug (CD) registers and they checked and verified the balances at the time they dispensed them. But they did not check and verify the balances of slow-moving stock so they could investigate and resolve anomalies in a timely manner. The pharmacy used loose sheets to record CDs that people returned for disposal. But this did not include the date the items were received into stock. Team members kept a signature audit trail to confirm destructions had taken place. And the pharmacist had authorised the ACPT to verify and sign the destructions that had taken place. 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 displayed a notice that provided information about its privacy arrangements. This provided assurance that it kept confidential information safe and secure. Team members knew to protect people's privacy and they used an on-site shredder and off-site supplier to collect and dispose of confidential waste. Team members discussed safeguarding concerns with the pharmacist to protect vulnerable people. For example, when people did not collect their medication on time. And when people made excessive requests for codeine-containing medicines.

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 long-serving pharmacist manager monitored staffing levels. They had appointed a new full-time dispenser who was about to take up post to replace someone that had left. They had also recently appointed an extra pharmacy student to work on a Saturday. Another pharmacy student also worked on a Saturday and provided cover when needed. The following team members were in post; a full-time pharmacist, one part-time pharmacist that provided cover once a week, one full-time ACPT, one part-time ACPT, one full-time dispenser, one part-time dispenser, one full-time trainee pharmacy technician, three part-time medicines counter assistants, two part-time delivery drivers and two part-time pharmacy students. The pharmacy had minimum staffing levels in place and the superintendent pharmacist (SI) sometimes provided cover when necessary. This helped with the pharmacy's continuity arrangements.

The company supported team members to develop in their roles and provided them with opportunities to undergo qualification training. The pharmacist had qualified as an independent prescriber (PIP) and they encouraged team members to enrol on training courses. One of the dispensers had agreed to undergo training, so they were accredited to carry out final accuracy checks. Another dispenser was undergoing training, so they were eligible to register as a pharmacy technician. The pharmacist provided protected learning time, and at the time of the inspection the trainee was completing coursework. The pharmacy employed two delivery drivers that had worked at the pharmacy for around two years. But the pharmacist could not confirm whether they had completed the necessary qualification training and undertook to enrol them if necessary to meet requirements.

Team members understood their obligations to raise whistleblowing concerns, and knew when to refer concerns to the pharmacist. The pharmacist encouraged the pharmacy team to suggest improvements to the pharmacy's working arrangements. And team members provided several examples that had improved their working arrangements. This included changing the procedures for multi-compartment compliance pack dispensing. And introducing wipe able laminated cards to label individual storage boxes so they could easily update them with relevant information when necessary. The pharmacist attended prescribing review meetings that were organised by the Health Board. This helped them to develop in their prescribing role.

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 team managed the available workspace well to ensure dispensing procedures were conducted safely and effectively. They had designated workstations depending on the various tasks they carried out. This included a separate rear area for the dispensing of multi-compartment compliance packs. This ensured there was sufficient space to layout the required components and to de-blister medicines before placing them in the packs. The pharmacist had good visibility of the medicines counter and could intervene when necessary.

The pharmacy had a separate dedicated consultation room that was well-equipped and lockable with cold running water. It also provided an environment for people to speak freely with the pharmacist and other team members during private consultations. There was a clean, well-maintained sink in the dispensary that was 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, and it stores them appropriately. The team conducts checks to make sure medicines are in good condition and suitable to supply. And they identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy had an automatic door and it provided access via a step-free entrance which helped people with mobility difficulties. The pharmacist manager provided the NHS Pharmacy First Plus service and provided treatments for acute common clinical conditions. They communicated their prescribing decisions when appropriate with the person's GP. This ensured their medical records were kept up to date. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were fit for purpose. This included checks of expiry dates which were documented on a date checking matrix to show when checks were next due. They also attached labels to highlight short-dated items, and sampling showed that medicines were in date. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. And team members read the temperature every day and kept records to show that fridges remained within the accepted range of between two and eight degrees Celsius. The fridge was organised with items safely segregated which helped team members manage the risk of selection errors. Team members used secure cabinets for some of its items. Medicines were well-organised and items awaiting destruction were kept segregated from other stock. The pharmacy kept stock of drugs used for palliative care as agreed by the Health Board. And team members ensured they checked the stock levels and expiry dates so the drugs were available for use.

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 carried out the necessary checks which included removing affected items and isolating them from stock. The pharmacy had medical waste bins and denaturing kits available 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 containers were colour coded and this helped with dispensing tasks, such as prioritising prescriptions according to when they were needed. The pharmacy supplied some people with multi-compartment compliance packs to help them with their medicines. Team members obtained an accuracy check before they placed medicines in the packs. This helped to identify and correct selection errors. Supplementary records helped team members manage dispensing to ensure people received their medication at the right time. They referred to records that provided a list of people's current medication and the time of the day it was due. And they checked new prescriptions for accuracy and kept records up to date. A template form was used to communicate prescribing changes. And once

actioned it was kept with peoples records and referred to when necessary. Some people arranged collection of their packs. And team members monitored the collections to confirm they had collected them on time. This helped them to identify when they needed to contact the relevant authorities to raise concerns. A notice board listed the names of people that had been admitted to hospital. This ensured that packs were isolated until further notice. The pharmacy used an automatic dispensing machine for some of its medicines. The pharmacists carried out a clinical and accuracy check before entering new prescriptions onto the system. They also carried out a final accuracy check at the time of supply.

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 also used an automated dispensing machine and team members cleaned and calibrated the machine each morning before use. This ensured it accurately measured the required doses. A blood pressure monitor was available for use in the consultation room. But the pharmacy had not considered keeping records to ensure the monitor was calibrated or replaced on a regular basis. 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.

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.