General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Amiry & Gilbride Pharmacy & Travel Clinic, 35 Meiklewood Road, Glasgow, G51 4GB

Pharmacy reference: 9012263

Type of pharmacy: Dispensing hub

Date of inspection: 31/07/2024

Pharmacy context

This is a hub pharmacy in Glasgow. It dispenses medicines against NHS prescriptions for other retail pharmacy businesses. It dispenses some of the medicines in compliance pouches which help people take their medicines properly.

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 Governance	Standards not all met	1.1	Standard not met	Team members are referring to SOPs that are out of date and some SOPs have not been approved by the SI. So there is a risk team members may not be following appropriate procedures.
		1.2	Standard not met	The pharmacy does not have appropriate monitoring arrangements for all its dispensing procedures to ensure its team members adequately learn from their mistakes and make improvements to keep services safe.
		1.3	Standard not met	The pharmacy does not have an operating structure that clearly identifies where responsibility lies for the services it provides.
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 not all met	4.2	Standard not met	The pharmacy does not have adequate accountability structures in place to show that pharmacy services are provided safely and effectively.
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 have an operating structure in place that defines the roles and responsibilities of the pharmacy professionals involved in the pharmacy's operation. The pharmacy has written procedures for providing its services which team members follow. But it was using out-of-date procedures for some of its dispensing processes and had not carried out a recent review to show its services were safe. Team members shared some learnings following mistakes they made during the dispensing process. But they did not keep records of the mistakes, and this meant they may miss opportunities to make safety improvements. Pharmacy team members know what steps to take to help keep vulnerable people safe from harm. And they keep people's confidential information secure.

Inspector's evidence

The pharmacy had been operational since December 2024, and it had been dispensing medicines against NHS prescriptions for several pharmacies trading under two pharmacy names; Amiry Gilbride pharmacies and Gilbride pharmacies. The retail pharmacies were owned by different companies and had separate superintendent pharmacists (SIs). The pharmacy did not have a documented operating structure to show the pharmacy’s hierarchy and the roles and responsibilities of the two SIs and the responsible pharmacists (RPs) that worked there. And there was not a clearly documented process to show who had overall accountability for having safe systems of work in place. So the pharmacy could not provide the necessary assurances that the risks associated with the pharmacy services were being adequately managed.

The pharmacy had a range of standard operating procedures (SOPs) for the team members to follow. But they did not make reference to the Amiry Gilbride pharmacies and the Gilbride pharmacies that it dispensed for. And they did not describe the working practices that were in place for each of them. The SOPs included procedures for the operation and management of an automated dispensing machine to assemble and label compliance pouches for community pharmacies. The SOPs were dated February 2019 but there were no annotations to show they had been updated since then. Most of the team members that operated the automated dispensing machine had recently read and signed the SOPs to confirm their understanding and ongoing compliance. But a few team members had yet to sign them. This included the accuracy checking pharmacy technician (ACPT) who worked there regularly. Separate SOPs were used to define the processes for dispensing medicines in their original packs using barcode technology. Most of the SOPs were dated to show they were valid until February 2025 and team members had signed and dated them to confirm their understanding and ongoing compliance. But a few of the dispensing SOPs had been developed and implemented by the pharmacy team themselves. And they had not been signed or annotated by an SI to show they had approved them for use. This included the SOP for the assembly and labelling of original packs. The pharmacists at the community pharmacies conducted clinical checks of prescriptions and accuracy checks of prescription information before transmitting the prescription details to the pharmacy for dispensing.

The pharmacy used an automated dispensing machine to prepare medicines in a compliance pouches. This used a combination of barcode and optical scanning technology which recorded a photograph of each individual medicine and highlighted any anomalies it detected. Only pharmacists and ACPTs carried out quality checks and corrected damaged items or those that were not visible to the technology. The authorised team members corrected the anomalies, but they did not keep any documented near miss error records to identify patterns and trends to make safety improvements or to inform the automated dispensing machine's manufacturer. An ACPT had day-to-day responsibility for compliance pouch dispensing. They were in the process of printing new components for the cartridges that held the medicines in the automated dispensing machine. This was due to some medicines being incorrectly released from some of the cartridges resulting in near miss errors. The ACPT described a recent dispensing mistake that someone reported after receiving their compliance pouch. The person reported they hadn't received the correct number of doses that were due. The ACPT investigated the complaint and after inspecting the photographs of the affected pouches they confirmed the error, corrected the dispensing mistake, and made a new supply. Team members responded to an alarm function on the automated dispensing machine when it detected an error. They placed the affected pouches in baskets and isolated them until a dispenser carried out a visual check. This involved checking the picture of the pouches against the expected contents and carrying out a pouch repair to correct the error if necessary. Once the error was corrected, they obtained an accuracy check from a pharmacist or an ACPT and saved a photograph of the new pouches on the system.

Team members provided a few examples of safety improvements for original pack dispensing following near miss errors. But they did not keep documented records of the mistakes to identify patterns and trends. Team members had introduced different coloured dispensing baskets to be used at workstations located next to each other. This prevented team members placing items in the wrong baskets by mistake. They discussed mistakes at the time they happened. For example, they had highlighted the difference between Fostair inhaler and Fostair NEXThaler due to selection mistakes. Team members had introduced a signature audit trail to show who had selected items to be dispensed from a picking list and to allow the pharmacist and the ACPT to provide team members with feedback so they could learn from their mistakes.

Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. But it could not show the arrangements covered the operations for the two pharmacy businesses. The pharmacist displayed a RP notice and the RP record was up to date. Team members kept prescriptions electronically so they could easily retrieve them if needed. The pharmacy trained its team members to safeguard sensitive information. This included the safe and secure disposal of confidential waste which was collected by an approved provider for offsite destruction. Team members knew to follow the pharmacy's policy whenever they had safeguarding concerns. And they knew escalate concerns to protect vulnerable adults and children.

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 monitored its staffing levels to make sure the pharmacy had the right number of suitably trained staff. It acted on any shortfalls and appointed new team members to help provide the pharmacy's services safely and effectively. The SI that was accountable for the Amiry Gilbride pharmacies and the SI that was accountable for the Gilbride pharmacies worked at the pharmacy. And the RPs at the community pharmacy businesses sometimes provided cover when needed. The pharmacists were supported by two dispensary managers. They included an ACPT manager who was responsible for the day-to-day management of compliance pouch dispensing. It also included a trainee pharmacy technician who had responsibility for original pack dispensing.

The following pharmacy team members dispensed compliance pouches; one full-time manager, three full-time dispensers, one full-time trainee accuracy checking dispenser (ACD), one full-time trainee dispenser and one part-time pharmacy student. An ACPT provided regular cover and was on duty at the time of the inspection. The following team members dispensed original packs; one full-time manager, one full-time dispenser, five full-time trainee dispensers, four part-time trainee dispensers and a pharmacy student. A transport manager was responsible for 25 delivery drivers, and they had been enrolled on the relevant qualification training within the required timescales.

The pharmacy had induction procedures in place for its new team members. The company used a mobile Application to document its induction activities and the human resource (HR) department monitored the records to confirm progress. It also highlighted gaps and liaised with the dispensary managers so that induction was completed on time. Induction activities included the reading and signing of the pharmacy SOPs and policies including data protection and safeguarding arrangements. This provided the necessary assurances that they understood and would adhere to them. One of the experienced dispensers visited the community pharmacies and delivered training before they started sending prescriptions for medicines to be supplied in compliance pouches. This ensured they followed the necessary working practices to keep services safe and effective.

The pharmacy had contingency arrangements in place for backfill when team members were on leave. And the team members sometimes supported the community pharmacies and provided cover when necessary. This also provided the trainee dispensers with the opportunity to gain experience of working in pharmacies with face-to-face contact with people about their medicines. The pharmacy enrolled new team members onto qualification training within the necessary timescales and it provided them with protected learning time in the workplace. A pharmacist at one of the community pharmacies was mentoring the trainee pharmacy technician. This ensured they were supported in their studies and made satisfactory progress. Team members shadowed colleagues to develop their knowledge and skills before carrying out tasks on their own. And some of them were learning about the operation of the automated dispensing machine so they could provide cover when needed.

The managers liaised with their peers at a similar pharmacy that was also owned by the company, and they supported each other to learn and develop in their roles. Team members attended a regular performance appraisal and the pharmacy provided opportunities for development such as enrolment on ACD qualification training. The pharmacy encouraged team members to provide feedback to keep services safe and effective. And they provided examples of recent changes that had been implemented. This included rearranging stock, so it was non-alphabetised to manage the risk of picking errors from a picking list. The pharmacy trained team members so they understood their obligations to raise whistleblowing concerns and they knew when to refer concerns to the pharmacist or another team member.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are clean, hygienic, and secure.

Inspector's evidence

The pharmacy was in large, modern purpose-built premises which provided ample space for its services. This included two separate dispensaries one of which was used to dispense compliance pouches using an automated dispensing machine and the other for dispensing original packs. The dispensaries were well-organised and provided a series of shelves and bench space for dispensing and associated tasks. Team members used designated workstations, and they used a separate room to remove medication from the manufacturer's foil strips for use in the automated dispensing machine. Drivers used a large separate area to sort items for delivery and they kept the areas neat and tidy and free from congestion.

The pharmacy had safeguards in place to restrict access to the pharmacy, and people pressed an access control button to alert team members. Well-equipped offices were available. And these provided suitable areas for activities that required extra safeguards to manage confidentiality. Team members cleaned and sanitised the pharmacy on a regular basis and washing arrangements were also available. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. All areas were organised and free from slips, trips and falls hazards.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not have adequate accountability structures in place to provide assurance that pharmacy services are delivered safely and effectively. 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 acted as a hub pharmacy and dispensed medicines against NHS prescriptions for several other community pharmacies six days per week from Monday to Saturday. But it did not have a clearly documented process for the pharmacy services that were being provided. And it had not defined the responsibilities of the hub pharmacy and the community pharmacies. Team members explained that people didn't contact the hub pharmacy about their medicines and they knew to contact their community pharmacy directly when they needed to. Details about the community pharmacy were provided on the medicine labels, such as its name and postal address. The community pharmacies contacted the hub pharmacy to discuss any changes so that supplies were in accordance with new prescriptions. 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 regular checks of expiry dates which they documented on a date-checking matrix to show when checks were next due. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. And team members read and recorded the temperature every day 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. The pharmacy received drug alerts and recall notifications and the 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 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 recent legislative changes which required supplies to be made in the original manufacturer's pack unless in exceptional circumstances.

The pharmacists at the community pharmacy branches were responsible for carrying out clinical and accuracy checks on prescriptions before they were sent to the pharmacy. This provided assurance that prescription requirements and the directions on the medicines label were clinically appropriate. The pharmacists at the community pharmacies submitted the prescription information required for dispensing and team members at the pharmacy assembled and dispensed them. The pharmacy dispensed compliance pouches for some of its community pharmacy branches and it was planning to increase the number of pouches it dispensed once it had increased its capacity and capability. This included the introduction of a separate IT network and the training of more team members to operate the automated dispensing machine. A separate room was used by team members to transfer medicines from the manufacturer's original packs into containers. The contents of the containers were then placed into the cartridges in the automated dispensing machine when they were depleted. Team members labelled the containers with details that included the medicine name, strength, the batch number, the expiry date, and a unique bar code for the medicines. A signature audit trail also showed the team members that were responsible for de-blistering and checking the contents of the containers. The pharmacy used barcode scanning technology to scan the unique barcode on the canisters and the labels on the containers. This ensured the canisters were refilled with the correct medication. The system manufacturer provided information about medicines that had been removed from the manufacturer's original packaging. And this helped the team identify medicines that were not suitable to be dispensed in this way. The base of the canister was a unique shape, and this meant it could only be placed in the machine in one location. The pharmacy had recently purchased a printer that produced the bases for the canisters to suit the size and shape of the various medicines. Access to the system was restricted to authorised and trained members using unique passwords. This helped to keep an audit trail of who had accessed the system and who had filled each individual canister. Not all medicines were dispensed from the canisters and team members manually added some higher-risk medicines to the system's removable tray to be dispensed into pouches from there.

After the medicines were dispensed into pouches, the pharmacy used photographic identification technology to scan the medicines in each pouch. The pharmacists and the ACPT completed a visual check of pouches that the system highlighted as having a potential inaccuracy or anomaly. Once completed, team members transferred a person's pouches into a box and attached dispensing labels so people had written instructions of how to take their medicines. They included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Each pouch also displayed printed information about its contents, including the name and quantity of each medicine, the day, date, and time the medicines should be taken and the person's details. Team members responded to prescription changes. They followed a procedure which involved removing items as required. They knew not to add items to pouches that had already been dispensed and they knew to supply new pouches when new items needed to be supplied.

Team members assembled and dispensed original packs using barcode technology to carry out accuracy checks. They only dispensed full packs and did not dispense part-packs to manage the risk of dispensing mistakes, such as quantity errors. Team members used individual log on credentials to create an audit trail of dispensing. And the patient medication record (PMR) automatically generated a picking sheet of items to be dispensed from the items on the prescription. Team members scanned packs and they were only able to print medicine labels when the correct item had been selected. They were also able to produce medicine labels manually, but they knew to obtain a final accuracy check from a pharmacist or an ACPT. Team members scanned the unique bar code on the medicine labels and once the technology confirmed that all items were correct, they placed the items in the prescription bag. Team members printed a bag label, which contained a unique barcode that included information about all the items in the bag. The PMR system was unable to print a bag label if it identified any dispensing mistakes.

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 which included the electronic BNF. The pharmacy had password-protected computers. And team members used separate office areas to hold confidential discussions. A cleaning schedule was in place for the automated dispensing machine and team members carried out various cleaning tasks accordingly. This helped to maintain the machine in good working order. The pharmacy had a service contract in place and immediate access to a service engineer. They were available to visit the pharmacy or to resolve problems remotely as required.

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.