General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 9-11 Inverurie Road, BUCKSBURN, Aberdeenshire, AB21 9LJ

Pharmacy reference: 1041654

Type of pharmacy: Community

Date of inspection: 16/10/2019

Pharmacy context

This is a community pharmacy close to a surgery on a main road into the city. It dispenses NHS prescriptions including supplying medicines in multi-compartmental compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. It offers flu vaccination, blood pressure measurement and diabetes testing. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines.

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 follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. And they review these mistakes and make changes to avoid the same mistakes happening again. Team members also review other incidents and processes. They discuss these and make changes to processes to improve services. The pharmacy keeps all the records that it needs to by law. And it keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were mostly followed for all activities and tasks. The team did not record information and changes on multi-compartmental compliance packs (Lloyds 'CDS') records as per the SOP. Pharmacy team members had read SOPs, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and this was confirmed from individual competency records. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services, with a 'onecall' menu with contact details. It also had a folder containing emergency information and contact numbers, including key holders.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They recorded contributory factors including the additional pressure during staff absence. They also recorded and reflected on errors leaving the pharmacy but there had not been any recently. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. A few months' previously the team had identified that two team members repeatedly dispensed the wrong strength of omeprazole. So, they put labels on the shelf to highlight this and the error rate improved. They have now removed the labels and do not make this mistake. A recent incident that was not an error was described and had resulted in improvements to a process. The GP practice had called to 'phone in' a prescription. It turned out to be a controlled drug, so the pharmacy team member explained this could not be taken by phone. A short time later a person had come to the pharmacy with the prescription. It was for a liquid that the pharmacy did not stock. The team member taking the phone call had made an assumption that it was tablets, and the doctor had not said what form it was. After reflection and discussion, the pharmacy team decided that in future team members would ask the person on the phone to read the full prescription before making any judgement. The pharmacy had a safer care board and a team member was appointed safer care champion. He undertook weekly safer care audits. And he recorded incidents to be aware of and highlighted similar packaging to remind colleagues to take care with these e.g. sertraline and the different strengths of flucloxacillin. He had a role supporting other branches in safer care in two health board areas. He tried to visit other branches, but it was challenging to leave the pharmacy with an inexperienced team.

The pharmacy had a complaints procedure and welcomed feedback. Team members ordered over-the-counter items in for individual people if appropriate on request.

The pharmacy had an indemnity insurance certificate, expiring 30 June 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and completed annual training. They segregated confidential waste for secure destruction. Some people using the consultation room may be able to see people's names and addresses on bags of dispensed medicines. Team members were aware of this and tried to manage it. Team members had also undertaken training on safeguarding. They knew how to raise a concern, and an example was described. The pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained or training team members to safely provide its services. The pharmacy compares team numbers with how busy it is. And it employs extra team members when required. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Pharmacy team members make decisions and use the professional judgement to help people. The team members discuss incidents. They learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager; one full-time trainee pharmacy technician; one part-time healthcare partner (31 hours per week, dispensary and medicines counter trained); two part-time trainee healthcare partners (both 12 hours per week), one had not started training yet; two pharmacy students each working eight hours, and two delivery drivers shared with other branches. One pharmacy student had previously worked in a pharmacy on a holiday placement and the other had no training. Typically, there were two or three team members and a pharmacist working at most times. At the time of inspection there was the trainee pharmacy technician and a trainee healthcare partner working. Team members were able to manage the workload. The pharmacy had recently reviewed staffing levels, then employed one pharmacy student and one part-time trainee healthcare partner. The new team members had read standard operating procedures, and the pharmacy students had been given copies of 'Counter Intelligence' to read. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided protected learning time for all team members to undertake regular training and development. It provided team members undertaking accredited courses with additional time to complete coursework. Team members explained that sometimes it was challenging to take time 'off-the-job' due to absence and inexperienced colleagues. The pharmacist and pharmacy technician were observed providing high quality coaching and supervision to the trainee healthcare partner.

Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacy kept records of interventions that the pharmacist or other team members made. Examples included identifying a person prescribed with a medicine they were allergic to; a once-a-day formulation prescribed twice a day; an antibiotic prescribed that had serious interaction with other medicines the person was taking and confusion regarding a child's dose of medicine – the parent had misinterpreted what the prescriber had said. The pharmacy team had resolved these ensuring that people received their medicine safely at the correct dose.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. Team members gave appropriate responses to scenarios posed. The company had a whistleblowing policy that team members were aware of. The pharmacy superintendent shared

information and incidents from elsewhere in the organisation for all team members to learn from incidents. Case studies were provided to promote discussion amongst teams. The pharmacy team members read these and discussed them. After reading and reflecting on these documents the team had moved 'lookalike, soundalike' (LASA) medicines into baskets to reduce the chance of them being supplied in error. This included gabapentin and pregabalin, and amlodipine and amitriptyline. They had also moved other items e.g. olanzapine. The company set targets for various parameters. Team members explained that this reminded them to offer services to people who may benefit.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy's services, although they are very small. The pharmacy team manages this space well. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were small premises with a very small dispensary and very small area incorporating staff facilities and some storage. The pharmacy fringe was in this room with other appliances on top of it. The dispensary was challenging to work in with medicines stored on very high shelves. Some shelves were observed to be used with a lot of weight on them. This shelf had recently been replaced. The dispensary had very limited dispensing bench space. But the team managed the space well and it was observed to be tidy and well ordered. The small back shop area was cluttered as there was inadequate storage space. A team member explained that recently some stock had been allocated to the pharmacy from head office. The team was trying to take back control to limit this. The premises were clean and hygienic. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People could see activities being undertaken in the dispensary if they were accessing the consultation room, or some retail shelves. Team members explained that occasionally people started to walk into the dispensary as they did not realise that it was not for public access. The pharmacy stored dispensed medicines on shelves opposite the consultation room door, so people's names and addresses could potentially be seen by people leaving the consultation room. Team members tried to manage this by positioning themselves between these medicines and people. The consultation room was furnished with a desk, chairs, and computer. It was clean and tidy, and the door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources. And it stores them properly. The pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and team members helped with the door if required. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They were very limited for space in the dispensary but managed this well. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The pharmacy's main workload was from collection service prescriptions which it received in the late morning. The team member labelling highlighted any new items or new patients to the pharmacist. She attached a label to this effect on the bag of dispensed medicines and a note if she wanted to speak to people. Team members provided effective counselling and information when handing out prescriptions. The team managed dispensing in two workflows. One for walk-in prescriptions which were managed at the front of the dispensary and placed for checking on pharmacists left hand side. And collection service prescriptions were managed on a bench at the rear of the dispensary with items for checking placed on the pharmacist's right hand side. Team members stacked these neatly to avoid congestion on the pharmacist's checking bench. And the two systems made it straightforward for the pharmacist to prioritise her workload. The pharmacist had devised an effective accuracy checking process which involved in the prescription out loud. This works well for her and other team members felt comfortable speaking to her about it if they felt she was speaking to loud. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the following day using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacist attempted to synchronise medicines when people started on this prescription type to enable compliance to be monitored. And this made medicines management more straightforward for people. The pharmacy dispensed these prescriptions the week before they were required using a reminder on the computer. It then stored dispensed items on a dedicated shelf which team members checked regularly and contacted people if they had not collected them as expected. The pharmacist explained that she had no concerns about people's compliance. When people did not collect their medicines as expected it was usually because they were not synchronised, and the person had a supply at home. The pharmacy was actively registering people for this service. The pharmacist explained that recently registrations had been done to reach a target. The consultations had been brief while the pharmacy had been short staffed. She was now endeavouring to undertake better quality consultations that would help identify pharmaceutical care issues during the registration process. She had more time to do this since

additional staff had been recruited. The pharmacist had identified some pharmaceutical care issues when discussing people's medicines with them. These included quantities and doses not matching. She discussed these with the practice pharmacist who was able to make changes appropriately. The pharmacist described enjoying a good relationship with both local GP practices. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. A team member assembled these most days after the main dispensing had been completed. The team managed this carefully to make best use of the limited space in the dispensary. There were often more team members working in afternoons. So one team member could undertake this activity with little distraction. The pharmacy was providing four packs at a time to some people even although prescriptions stated, 'dispense weekly'. The pharmacist was attempting to address this, having changed to weekly dispensing for some, and planning getting written authority from the prescriber for some others. The pharmacy recorded interventions and changes in a notebook used only for this purpose. Team members recorded these chronologically, so it was challenging to see a complete record of changes for individuals. And team members did not always record dates of changes and never recorded prescribers involved. And they were not using the Lloyds 'CDS patient record' as documented in the SOP. Sometimes they used paper correction fluid on the master backing sheet on the patient record, so dates and changes were nor visible. They kept these records in folders depending on the week of management. Team members supplied patient information leaflets to people each month. And they included tablet descriptions on backing sheets. And they wrote the person's name and date of supply on the outside of the pack. They left original packs with the assembled compliance packs to help the pharmacist accuracy check. And they left notes of changes or any other relevant information for the pharmacist to consider when checking the medicines. The team stored completed packs in the dispensary. But they were stacked on top of each other due to space constraints. This introduced risk that the wrong pack could be selected.

The pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She attached 'see pharmacist' labels onto medicines' bags. And she checked with people that they were having appropriate monitoring e.g. blood tests. And she checked that they carried their record books or other information. She also asked people to check that the pharmacy was supplying the correct insulin. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled carers. Team members were aware of the programme and the risks involved. They described how they would address the topic with new patients. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and supply of chloramphenicol ophthalmic products. It also followed private PGDs for flu. The pharmacy empowered team members to partially deliver the minor ailments service (eMAS) within their competence. They used the sale of medicines protocol and referred to pharmacist.

The pharmacist delivered a flu vaccination service. The pharmacy had only recently received stock of vaccines, so she had not done many. She had completed the relevant training and followed the PGDs. The pharmacy kept an anaphylaxis kit in a discreet but easily accessible area of the consultation room. It also kept additional adrenaline ampoules segregated in the dispensary as back-up following stock shortages. The pharmacist delivered the smoking cessation service although there were no people using it currently. The pharmacist and two team members were trained to measure blood pressure and test

for diabetes, but people did not request these services often. They followed a SOP and used a template to record information. Team members discussed results with the pharmacist before advising people.

The pharmacy obtained medicines from licensed wholesalers such as alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). It had the equipment on the premises, but team members had not yet been trained. They knew there was an online training module available and expected to complete it soon. Head office had sent an email the previous week requesting the team to complete the training and re-read the SOP. Team members demonstrated how they were going to have to review and change their dispensing workflow due to the location of the scanner. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. Scenarios yes.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy has the equipment it needs for the delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, a blood pressure meter which was replaced every two years and blood testing equipment calibrated as per the manufacturer's guidance. Team members kept crown stamped and ISO marked measures by the sink in the dispensary, and separate marked ones were used for methadone. They also kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in a locked cupboard in the consultation room and in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored on shelves opposite the consultation room door meaning personal information could be seen by people using the consultation room. Team members were aware of this and tried to address it. Team members used passwords to access computers and never left them unattended unless they were locked.

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.