General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 3 Orleans Place, DUNDEE, Angus, DD2 4BH

Pharmacy reference: 1041741

Type of pharmacy: Community

Date of inspection: 05/03/2020

Pharmacy context

This is a community pharmacy beside other shops in a suburb of a city. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services, the NHS smoking cessation service and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers additional services including seasonal flu vaccination, travel vaccination, human papillomavirus (HPV) vaccination, measles, mumps and rubella (MMR) vaccination, Vitality health screening, blood pressure measurement, diabetes testing and cholesterol testing.

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	1.2	Good practice	The pharmacy records and reviews mistakes and incidents. It learns from these and makes changes to avoid similar things going wrong again.
2. Staff	Standards met	2.2	Good practice	The pharmacy encourages team members to develop their skills. It does this in different ways and gives them time to learn.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy manages all services efficiently and effectively. The team has thorough systems in place and keeps good records of processes and interventions.
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 they provide them safely. They record mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to and keeps people's private information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which team members followed for all activities and tasks. Pharmacy team members had read them, 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 confirmed on individual records of competence. 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. It had a 'one call menu' on the wall so team members knew how to report maintenance or emergency issues.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. And they recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month, met and discussed them and introduced strategies to minimise the same error happening again. Recently team members had discussed the value in capturing more meaningful data and possible reasons for errors. This helped them when analysing the data. They did not make a lot of errors. But they had identified over the past few months that errors could happen on any day, typically before lunch and often involved incorrect quantities or strengths. Strategies introduced to minimise errors included team members trying to avoid answering the phone or other interruptions when dispensing and avoiding dispensing prescriptions for several items when also looking after medicines' counter. The team had made a few errors with Contour® and Contour Next®. So now the team member labelling highlighted 'next' on prescriptions to draw attention to it. The pharmacy had supplied a multi-compartment compliance pack to the wrong person a few months previously. The two people had very similar names. The team had separated storage of these and ensured all team members were aware. No harm had been done as the person identified the mistake. The pharmacy also carried out weekly audits as part of the company safer care programme. It audited the environment, processes and people. The pharmacist had done these recently but was in the process of delegating to other team members to ensure all were completely engaged.

The pharmacy had a complaints procedure and welcomed feedback. It never received complaints – head office had recently sent a card congratulating the team on this achievement. Several examples were described of people thanking the team for good service. And cards were observed.

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. Records were tidy and well organised. And old records were archived and labelled.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed the company policy. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a policy on safeguarding. They knew how to raise a concern. The pharmacy had a chaperone policy in place and displayed a notice telling people. The delivery driver was aware of people who were frail or suffering from conditions such as dementia. He was able to contribute to decision making about when to supply medicines early before public holidays. E.g. he described some people that may be given two weeks' supply at a time, and others who he would deliver the second supply later in the week to avoid confusion. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified team members to safely provide its services. The pharmacy compares staff numbers to how busy the pharmacy is. And then makes changes if required. This ensures skilled and qualified team members always provide pharmacy services. 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. Team members also learn from colleagues. And the pharmacy helps to train other professionals. Team members can share information and make suggestions to improve ways of working and to keep the pharmacy safe. They know how to raise concerns if they have any. The pharmacy team members discuss incidents from elsewhere. And they learn from them to avoid the same thing happening here.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, two full-time (one was also the supervisor)and one part-time (22 hours per week) dispensers, two part-time medicines counter assistants, and a part-time delivery driver. Typically, there were four team members and a pharmacist working. Except Mondays and Saturdays which were quieter. The pharmacy had a pharmacist and three team members these days. For six months of the year the pharmacy had a pre-registration pharmacist who was following a modular programme. She was currently undertaking a hospital placement. The pharmacist was involved in her training and met with her and the hospital tutor. Team members were able to manage the workload. Part-time team members had some scope to work flexibly providing contingency for absence. All team members were trained and experienced in their role.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. Recently team members had undertaken a training module about similar looking and sounding medicines (lookalike, soundalike, LASA). It identified individuals' development needs. And the pharmacist recorded these in the safer care documentation e.g. medicines skills, prescription counting, and safer care case studies such as colchicine in pregnancy. Two team members were currently learning how to carry out the Vitality health screening. They were shadowing experienced colleagues. The pharmacist was trained appropriately to deliver the travel and vaccination services. He was due to take refresher face to face training in a few months' time. Team members were trained to measure blood pressure and test for diabetes. And their certificates were displayed in the consultation room. The pharmacy was a student training site, so provided placements for pharmacy students, although it did not have any at the time of inspection. It also provided learning experiences for surgery team members. Trainee GPs often spent a morning in the pharmacy. And the practice pharmacist, practice manager and team members involved in printing prescriptions at the surgery had spent time observing pharmacy processes. This was described as valuable for all, providing the surgery team with an insight into pharmacy processes.

The various individuals 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. They usually referred these to the pharmacist to provide appropriate advice.

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. Team members had been involved with rearranging stock in the dispensary. The company had a whistleblowing policy that team members were aware of. Team members gave appropriate responses to scenarios posed. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read this document and signed to acknowledge this. It followed guidance on these documents, including separating LASA items such as amitriptyline and amlodipine. They had also relocated olanzapine preparations and prednisolone tablets following guidance from head office. And they applied labels to shelves to highlight these. And they stamped prescriptions to capture who had dispensed and checked these. They had regular monthly team meetings when patient safety topics from head office and within the pharmacy were discussed. The company set targets for various parameters. Team members described using these two remind people about services that they would benefit from.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. 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 incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The dispensary was very small with limited dispensing space. Team members kept this area tidy and followed robust processes acknowledging the challenges of little space. The pharmacy had a room behind the dispensary that team members used for the management of multi-compartment compliance packs. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The pharmacy also had a separate area with a hatch to the dispensary, for specialist services such as substance misuse supervision. Team members invited people into this area when their medicine was ready for supply. People could choose to close a curtain to maximise privacy. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they can all use its services. The pharmacy team provide safe services. Team members support people by providing them with information and suitable advice to help them use their medicines. And they provide extra written information to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a low step and an automatic door. It listed its services and had leaflets available on a variety of topics. It could provide large print labels to help people with impaired vision. 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. The pharmacy provided vitality health screening which was popular with the local community. And it offered travel vaccination and HPV and MMR vaccination. The travel vaccination service was not popular in this area. The pharmacy displayed the NHS recommended public information about COVID-19.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The dispensary was small with little dispensing space. But team members used dedicated dispensing areas, an area for 'holding' assembled medicines in baskets waiting to be checked, and a pharmacist checking area. Pharmacists checking area was clearly defined to ensure it was kept clear of any other medicines. The dispensing space had decreased as it included an additional (but needed) labeller, the 'methameasure' pump device and a scanner used for falsified medicines directive (FMD) scanning. One team member labelled then dispensed collection service prescriptions close to the supervision hatch. Another team member dispensed collection service and walk-in prescriptions on another small bench. Sometimes the pharmacist used the 'methameasure' device, adding to the congestion in this area. But team members were very aware of the challenges and described how they accommodated each other. Team members highlighted changes or new items to the pharmacist when they were labelling and dispensing. They initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. And they also initialled prescriptions for LASA item

s. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy sent these to an off-site hub the week before they were required. All team members were able to follow the process for this, and the pharmacist undertook clinical and accuracy check on the computer before these were submitted to the hub. The pharmacy had told people that their medicine was being assembled at a central location.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. The supervisor/dispenser had ownership for the management of these and assembled them in the room behind the dispensary around a week before the first supply was due to be made. All team members were trained and competent to undertake this. The pharmacy kept records for each patient, and these were observed to be thorough and neat. Records included changes, hospital discharges and other interventions. The GP practice often used templates to notify the pharmacy of

changes and these were retained. The pharmacy had reviewed this process over the past few months due to the number of people receiving medicines in packs increasing. The team member ordered prescriptions two weeks before the first supply was due to be made. And she kept a record of people's names, number of items ordered and date of supply. When she received prescriptions, she recorded receipt and ensured that they were correct. If not, she contacted the GP practice and took appropriate action. And she kept records of this. She processed the prescriptions on the computer in the consultation room where she was not distracted and was not in other team members' way in the dispensary. She then printed backing sheets and gathered stock, placing these in individual baskets per person. Team member explained that gathering stock for all prescriptions at this early stage identified any items that had ordered or the supply issues. She addressed these appropriately. Also, the labelling process generated an order, so as the stock was not removed from the shelves that could be confusion as to why more stock was ordered. She then worked through these in an appropriate order depending on date required and number of items. She included detailed tablet descriptions on backing sheets and ensured these were correct, making changes as necessary. The pharmacist checked and sealed packs in the dispensary. Then he placed the completed packs into individual boxes labelled per person. The pharmacy had dedicated shelves for packs supplied by delivery or collection. The dispenser labelled the outside of packs with patient details, instalment number and date of supply which corresponded to the date on the backing sheet. She used different coloured highlighters to draw attention to similar names. Some family members with similar names received medicines in compliance packs. And as noted above, people's packs involved in a patient safety issue had been separated into different areas. The pharmacy supplied patient information leaflets (PILs) with the first pack of each prescription. A pharmacist from another branch had carried out an audit of this process and suggested placing PILs into a bag which was easier to supply them the previous way of supplying them loose. The pharmacy had adopted this. The dispenser checked patient records periodically and reprinted patient profiles if there had been several changes made to them. The pharmacy used templates (PC 70 forms) to record supplies to people. And team members used labels attached to this form to record batch numbers and expiry dates of medicines supplied. They also did this for other items supplied by instalment.

The pharmacy supplied a variety of other medicines by instalment. A team member was responsible for these although all members of the team were able to do this. She kept lists of people receiving daily and weekly instalments, highlighting the day of supply. When prescriptions were received from the GP practice, she checked these and removed any instalments ones. And then dispensed these in their entirety. The pharmacist checked them, they were placed into individual bags which were labelled with patient details and date of supply. Then placed in boxes or baskets on dedicated shelves depending on whether they were four weekly or daily supply. These were stored in the back-shop area and at the start of each week a team member moved that week's instalments through to the dispensary. The pharmacy stored them close to the supervision hatch. Several people receiving methadone also received other medicines by instalment, so it helped the team to store them all in the same area. When the pharmacy received methadone prescriptions a dispenser or pharmacist put the data onto the 'methameasure' computer. A team member dispensed methadone into labelled cups when people presented at the pharmacy. The team member then invited the person into the supervision area and confirmed their identity by asking address, date of birth and what dose they were expecting. The pharmacy disposed of used cups in receptacles that were for that purpose and were removed from the pharmacy.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. He or a team member supplied written information and record books if required. 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 them appropriately. Team members

applied additional warning labels each time the supplied valproate. 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. All team members were knowledgeable about additional guidance and advice required. They kept a range of information to be supplied to people in a drawer in the dispensary. He documented advice given to people on patient medication records (PMRs). 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 vaccination. It also followed private PGDs for vaccinations. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. Team members provided good examples of how they dealt with requests and referred.

The pharmacy stored SOPs for additional services in folders which were easily accessible in the back-shop area. The pharmacist administered HPV vaccination quite often. This was following prescriptions from an online doctor, following a private PGDs and NHS 'mop-up' for people who had missed vaccination as part of the standard program. The travel service was in conjunction with the medical advisory service for travellers abroad (MASTA). People were directed to the website and then had a phone consultation before presenting at the pharmacy for vaccination. But the service was not busy and seldom used in this area. The vitality health screening was quite busy, and two team members were trained to deliver it. They showed all results to the pharmacist. He explained that he had made several referrals to GP. The pharmacy used an appointment system, usually two half days per week to manage these appointments. This enabled the pharmacy to manage its workload. The medicines counter assistants mainly delivered the smoking cessation service. And the pharmacist undertook consultations involving supply of Champix. All team members were trained to test for diabetes and measure blood pressure. But they did not do this often.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It complied with the requirements of the Falsified Medicines Directive (FMD). Medicines were scanned to decommission only at the point of assembly. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in two fridges with minimum and maximum temperatures monitored. Team members took appropriate action 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.

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

The 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 labelled with date of fist use, to ensure it was replaced as per the manufacturer's guidance; and blood testing equipment calibrated as per guidance. The pharmacy kept records of this calibration. Team members used antibacterial hand gel frequently. The pharmacy had this at the methadone supervision area and in the consultation room. And it kept gloves and sharps' boxes in the consultation room. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy had a 'methameasure' pump available for methadone use and team members cleaned it at the end of each day. And they poured test volumes each morning. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and in a locked cupboard in the consultation room inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people. 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.