

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 30A Russell Street, Chapelhall,
AIRDRIE, Lanarkshire, ML6 8SG

Pharmacy reference: 1042194

Type of pharmacy: Community

Date of inspection: 31/10/2019

Pharmacy context

This is a community pharmacy in the Chapelhall area of Airdrie. 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 dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It also offers a smoking cessation service and flu vaccinations.

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	1.8	Good practice	There is a clear culture of safeguarding the safety and wellbeing of children and vulnerable adults.
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. They provide safe services and look after people's welfare. The pharmacy keeps records of mistakes when they happen. And there is ongoing service improvement. The pharmacy keeps the records it needs to by law. And it provides regular training to keep confidential information safe. It understands its role in protecting vulnerable people. And team members complete regular training to ensure they are up-to-date with safeguarding requirements. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means that they listen to people and put things right when they can.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. And the team members had signed them to show they understood their roles and responsibilities. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. But, it was not visible from the waiting area. The pharmacy team signed dispensing labels to show they had completed a dispensing task. And the pharmacist and accredited checking technician (ACT) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The dispensers recorded their own near-misses. And provided some information about the contributing factors. The ACT carried out a monthly near-miss review. And the pharmacy team members discussed ways of managing the risks that they found. The ACT carried out weekly audits to confirm compliance with safety measures. For example, they checked that the benches were clear, and stock was safely stored. A sample of recent near-miss reviews showed the following actions had been agreed;

1. Separating Lyrica 25 and 225 to manage selection errors.
2. Reminding team members to record near-misses.
3. Ensuring labelling and assembly was carried-out by different team members whenever possible.

The pharmacist managed the incident reporting process. And team members knew when incidents happened and what the cause had been. For example, they knew when there had been a mix-up with pregabalin and gabapentin. And the team members had been instructed to re-read the working instructions to ensure they were following all the steps required. The pharmacy used a complaints policy to ensure that team members handled complaints in a consistent manner. And a leaflet informed people about the complaints process and how to provide feedback if they wished. The pharmacy received mostly positive feedback with no suggestions for improvement received.

The pharmacy maintained the legal pharmacy records it needed to by law. The pharmacist in charge kept the responsible pharmacist record up to date. And public liability and professional indemnity insurance were in place. The pharmacy team kept the controlled drug registers up to date. And checked and verified the balance of controlled drugs on a weekly basis. The team members recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions to improve access to medicines and advice.

And a sample trimethoprim patient group direction was valid until November 2019.

The pharmacy displayed a notice which provided people with information about its data protection arrangements. The pharmacy trained its team members on a regular basis to comply with data protection arrangements. And they knew how to safeguard personal information. The pharmacy disposed of confidential information in designated bags. And it archived spent records for the standard retention period.

The pharmacy displayed a chaperone notice beside the consultation room. And the protecting vulnerable group (PVG) scheme was used to help protect children and vulnerable adults. The pharmacy used a safeguarding policy to train the pharmacy team members. And they kept contact details up to date, so they could make timely referrals if they needed to. The pharmacy team knew to refer concerns to the pharmacist when they recognised the signs and symptoms of abuse and neglect. And they documented and reported serious concerns to the superintendent's office who provided support.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And identify and discuss their learning needs at review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And the pharmacy team members support each other in their day-to-day work. They can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy had experienced a slight growth in the number of NHS prescription items it dispensed over the past year. And it had appointed a new team member so there was enough capacity to safely provide the services it needed to. The new team member had started the Monday before the inspection. And she was currently undergoing induction before being enrolled onto the dispenser's training course. A new pharmacist had taken up post in April 2019. And was about to carry-out the annual performance review to identify development goals for each team member. For example, discussing the NVQ pharmacy services level 3 course with one of the dispensers. And recommending more training to support team members to provide advice whilst providing over the counter medicines.

The team members were experienced and had worked at the pharmacy for a significant length of time. The pharmacy kept training certificates on-site. And the following team members were in post; one full-time pharmacist, one full-time accuracy checking technician (ACT), two full-time dispensers, one part-time dispenser, one full-time medicines counter assistant (MCA), one Saturday MCA and one delivery driver. The pharmacist managed annual leave with only one team allowed to take leave at the one time. And the Saturday assistant provided cover when the pharmacy team needed extra support.

The pharmacy used records to keep track of training. And the team members were up-to-date with company requirements. For example, they had been recently trained so they had the knowledge and skills to safely sell Otrivine nasal sprays. The pharmacy trained team members to carry out blood glucose and blood pressure checks. And the company provided a policy and work instructions to support them to do so.

The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had recently discussed the need to review the workload. And the team members had recognised the need to prioritise prescriptions that people wanted to wait on. The team members ensured that a three-way check was in operation when they were able to. And made sure that separate people labelled, assembled and checked each prescription to manage the risk of dispensing errors. The pharmacy team members recorded their near-misses. But, they did not always provide the reason for them. And this prevented them from learning from each other.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises is secure, clean and hygienic. It has a consultation room that is professional in appearance. And it is an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

A well-kept waiting area presented a professional image to the public. The pharmacy provided seating and provided patient information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. And a side room was used to dispense and store multi-compartment compliance packs. The pharmacist supervised the medicines counter from the checking bench. And could make interventions when necessary. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy provided a consultation room and a separate private booth which were professional in appearance.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy obtains its medicines from licenced wholesalers. But it doesn't always re-label medicines when they are removed from their original packaging. And this means that the team members may not always be able to identify medicines when they need to. The pharmacy keeps the team members up-to-date about high-risk medicines. And team members know when to provide people taking these medicines with extra information. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services are available to them.

Inspector's evidence

The pharmacy had step-free access and there was unrestricted access for people with mobility difficulties. The pharmacy displayed its opening hours in the pharmacy window. And displayed leaflets in the waiting area and in the consultation room. The pharmacy team members identified people that were suitable for the chronic medication service (CMS). And they stamped prescription at the time of labelling to identify people when they collected their medication. The team members alerted the pharmacist. And they spoke to people about their medicines and identified any difficulties they may be having. The pharmacy team used dispensing baskets. And kept prescriptions and medicines contained throughout the dispensing process. The team members annotated prescriptions when there was more than one prescription form. And this helped them to monitor prescriptions and keep dispensing safe. The pharmacist attached stickers to prescription bags. And this helped team members to communicate safety messages, such as checking that people taking warfarin were having regular blood checks.

The pharmacy dispensed multi-compartment compliance packs for around 80 people. And the team members had read and signed the company's working instructions to confirm that dispensing was safe and effective. The team members dispensed the packs on a Saturday and a Monday when it was quieter. And they used a separate side room to assemble and store the packs. The team members used electronic records to support the dispensing process. And this ensured that people received their medication in a timely manner. The team members obtained signatures to confirm which pack had been collected. And this helped them to monitor supplies and to identify potential compliance issues which they referred. The team members removed and isolated packs when they were notified about prescription changes. And they completed a 'change-sheet' which was kept in the person's medication record. The pharmacy team members supplied patient information leaflets. And they provided descriptions of medicines. The accuracy checking technician (ACT) carried-out final accuracy checks. And she reviewed each prescription before she checked the medication to ensure they had been annotated by a pharmacist.

The team members kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers. The pharmacy kept controlled drugs in two well-organised cabinets and this managed the risk of selection errors. The pharmacist supplied methadone doses to around five people. And he dispensed the doses a week in advance to maximise dispensing time. But, he had decanted what looked like methadone into a large unlabelled bottle. And this meant that the contents could not be confirmed by any team member other than him. The pharmacy team carried out regular stock management activities. And highlighted short dated stock and part-packs during regular

checks. The team members monitored and recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees Celsius. The pharmacy used clear bags instead of paper prescription bags for controlled drugs and fridge items. And this allowed the pharmacist to easily carry out additional checks at the time of supply. The pharmacy used one fridge to keep stock. And they used another for dispensed prescriptions awaiting collection or delivery.

The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected. The pharmacy team members acted on drug alerts and recalls. And recorded the date they checked for affected stock and the outcome. For example, they had acted on an alert concerning ranitidine in October 2019 with stock identified and returned to the supplier. The pharmacy team members had completed e-learning and knew about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards. The pharmacist monitored prescriptions for valproate. And added flash notes to the PMR to highlight people that were affected. The pharmacy team had been trained about the Falsified Medicines Directive (FMD) and what it aimed to achieve. But the company had not introduced system. And the team members reported it was due to be introduced at the start of November 2019.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. And the team members had labelled measures for methadone. The pharmacy team members used a blood pressure monitor. And they had attached a dated label to show when a calibration was next due. The pharmacy team members used a blood glucose monitor. And they kept records to confirm it was being calibrated at least every 13 weeks. The pharmacy provided cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used a portable phone. And they took calls in private when necessary.

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.