General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: LloydsPharmacy, 201 Abercromby Street, GLASGOW, Lanarkshire, G40 2DA

Pharmacy reference: 1042259

Type of pharmacy: Community

Date of inspection: 16/11/2022

Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS and private prescriptions and provides a substance misuse service. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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

Pharmacy team members follow good working practices. And they manage dispensing risks to keep services safe. Pharmacy team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. Team members make records of mistakes and use this information to review the pharmacy's processes and procedures. They learn from mistakes and take the opportunity to improve the safety of services.

Inspector's evidence

The pharmacy had control measures to manage the risks and help prevent the spread of coronavirus. This included a plastic screen at the medicines counter. And the placing of hand sanitizer at the entrance and throughout the dispensary for visitors and team members to use. The company used 'standard operating procedures' (SOPs) to define the pharmacy's working practices. And team members annotated records when they had read and understood them. Sampling included 'responsible pharmacist' and 'accuracy checking' procedures and showed the pharmacy kept them up to date. The pharmacy also had policies in place for the services it provided. This included diabetes checks and blood pressure monitoring. The company had recently issued new SOPs for the dispensing of 'multi-compartment compliance packs' (MDS). And team members had evidenced that they had read and signed them. The 'accuracy checking technician' (ACT) had read and signed the relevant SOPs for their roles and responsibilities. And they knew only to check prescriptions that had been clinically checked and annotated by the pharmacist.

Dispensers signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist was able to help individuals learn from their dispensing mistakes. The company had introduced bar-code scanning technology that helped to identify selection errors. And team members were gradually introducing the system and using it when it was easy to do so. This included for items that people collected at the time, when they handed prescriptions in. Team members recorded some near miss errors. And they were focussing on improving the level of near miss reporting. The pharmacist and the trainee pharmacy technician reviewed the records at the end of the month. And they discussed patterns and trends with the rest of the team. Team members had agreed and introduced changes to manage dispensing risks. This included separating items such as 'look alike sound alike' (LASA) items such as olanzapine and omeprazole. And adding shelf edge caution labels to highlight items with different strengths. Team members knew to record dispensing incidents on an electronic template which they sent to the superintendent's office. The template included a section to record information about the root cause and any mitigations to improve safety arrangements. The pharmacy provided information about its complaints process in a company leaflet. And team members displayed the leaflet in the waiting area for self-selection. The area manager visited the pharmacy on a regular basis. And they carried out audits to confirm the pharmacy was operating safely and effectively. They provided feedback following the audits and highlighted areas for improvement if required. Following a recent audit, team members had agreed to focus on completing the pharmacy's weekly audits. And sampling showed this to be up to date at the time of the inspection. For example, team members had documented that the date-checking matrix had not been completed.

Team members maintained the records they needed to by law. And the pharmacy had public liability

and professional indemnity insurances in place which were valid until June 2023. The pharmacist displayed a responsible pharmacist notice which was visible from the waiting area. And they were using a paper-based RP record as an interim measure until they could access the electronic RP record. They had reported the issue to the area manager who had provided assurance that the company was aware of the issue. Team members maintained the controlled drug registers and kept them up to date. Records showed they mostly carried balance checks every week. People returned controlled drugs they no longer needed for safe disposal. And team members used a CD destruction register to document items. The pharmacist signed the register to confirm items had been safely disposed of. Team members filed prescriptions so they could easily retrieve them if needed. They kept records of supplies against private prescriptions that were up to date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. And a policy was available for them to refer to. They used a designated container to dispose of confidential waste. And an approved provider collected the waste for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And it provided a policy for them to refer to. A list of contact details for local agencies was prominently displayed on the dispensary wall. Team members knew to speak to the pharmacist whenever they had cause for concern. This included concerns about vulnerable people that failed to collect medications that were due. A chaperone notice advised people they could request to be accompanied whilst in the consultation room. And an Ask for ANI (Action Needed Immediately) poster was displayed so that people at risk or experiencing domestic violence could ask for help.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they work together to suitably manage the workload. The company supports team members to develop in their roles. And they continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's prescription workload had remained mostly the same over the past year. The company was reducing the number of working hours in the team. And the pharmacy was in the process of replacing an 'accredited checking technician' (ACT) for fewer hours. A regular pharmacist manager had been in post for around two years. And the pharmacy team comprised long serving and experienced team members. The pharmacy operated Monday to Friday. And the pharmacist planned leave so the company could arrange locum cover well in advance. The pharmacist permitted up to two people at a time to take annual leave. And a part-time dispenser provided annual leave cover when needed. An area manager visited the pharmacy on a regular basis. And they supported the branch to ensure it was operating safely and effectively. This included arranging cover such as relief dispensers. A relief dispenser was working at the time of the inspection. And they were due to work there up until December 2022. A sister branch was located on the opposite side of the street. And the pharmacies supported each other when they could.

The pharmacy team comprised one full-time pharmacist, one part-time 'accuracy checking technician' (ACT), one part-time trainee pharmacy technician, one full-time dispenser, one part-time dispenser, one part-time trainee dispenser, one full-time pharmacy assistant, one delivery driver and one trainee pharmacist. A full-time pharmacy assistant had been working in the pharmacy since February 2022. The pharmacist had not enrolled them onto the relevant qualification training, and this was being planned for the next few months. A trainee pharmacy technician was undertaking the NVQ pharmacy services level three qualification. But had paused the training due to time constraints. A trainee dispenser had recently returned from a period of leave. And they were about to recommence training. They had re-read the relevant SOPs. And the pharmacist monitored their performance to check if they needed extra support.

The pharmacist supported team members to learn and develop and provided protected learning time in the workplace when possible. A trainee pharmacist had recently taken up the post. And the pharmacist was supporting them whilst they completed the company's induction procedures. This included reading the relevant 'standard operating procedures' (SOPs) and completing health and safety training. The company delivered mandatory training via its online operating system. And team members had completed annual mandatory training, such as pharmacovigilance topics in July 2022. This included adverse events and drug recalls and drug alerts. The company issued case studies and learnings in response to trends. And team members had recently re-read about the risks associated with valproate medication.

Team members had individual usernames and passwords that linked to individual records to evidence training. And they had completed training to enable them to use the new online operating system that

the company had recently introduced. Trainers had also attended the pharmacy to support the team and to provide extra training if needed. The pharmacist had recently completed 'pharmacist independent prescriber' (PIP) training. And they were planning on providing the NHS pharmacy first plus service sometime soon. The pharmacist kept the pharmacy team up to date with local news items. For example, they recently discussed a fraudulent prescription and cascaded the information as required by the NHS.

The trainee pharmacy technician and the pharmacist shared the findings from the pharmacy's patient safety audits. And they discussed dispensing mistakes to help them improve their accuracy in their dispensing. Team members were proactive at suggesting improvements to their working practices. For example, the trainee pharmacy technician had suggested attaching a calendar to the side of each of the storage boxes they used for multi-compartment compliance packs. This helped team members to monitor the supplies that they made. Team members were aware of whistleblowing procedures. And they felt empowered to speak up if they had a concern.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of services. And the pharmacy suitably manages the space for the storage of its medicines. The pharmacy has appropriate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was in large modern purpose-built premises. And it was co-located alongside nine medical practices in a large health centre. A sound-proofed consultation room with hot and cold running water was available for use. And it provided a clinical environment for the administration of vaccines. It also provided a confidential environment for private consultations. The pharmacist disposed of clinical waste in a designated container. And they removed the container and kept it in the dispensary in between sessions. A sink in the dispensary was available for hand washing and the preparation of medicines. And a dedicated area for comfort breaks was available for team members to use. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services.

Team members had organised the benches in the dispensary for different tasks. And a separate area at the rear of the pharmacy provided extra space to carry out dispensing tasks. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. But it doesn't do enough to identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy had a step-free entrance and an automatic door to provide unrestricted access for people with mobility difficulties. It advertised its services and opening hours at the front of the pharmacy. And it had a range of health information leaflets on display in the waiting area. The pharmacy was offering appointments for flu vaccinations. And team members directed people to the online booking system to make an appointment. This helped the pharmacy team to manage their workload and maintain service continuity. The booking system linked to an ordering system. And once an appointment was made the vaccine was sent in time for the appointment. An online doctor provided private prescriptions for 'Human Papillomavirus) (HPV) vaccinations. The pharmacist administered three vaccinations over a period of six months. And they recorded supplies in the private prescription register and on the pharmacy's online system.

Team members kept stock neat and tidy on a series of shelves and drawers. And they used secure cabinets to store some items. The pharmacy purchased medicines and medical devices from recognised suppliers. And the pharmacist reviewed the order before it was placed to maintain adequate stock levels and to avoid the build-up of unnecessary stock. A date checking matrix was available to keep track of when checks were next due. But it had not been updated for some time. Sampling showed a few out-of-date items, and these were removed and disposed of at the time of the inspection. A large glass-fronted fridge kept medicines at the manufacturers recommended temperature. And another small fridge was used to store vaccines. Team members monitored and recorded the temperatures every day. This provided assurance that the fridges were operating within the accepted range of two and eight degrees Celsius. Team members checked the company's online system for drug alerts. And they were expected to update the system once they had carried out the necessary checks. The system showed a recent drug alert for metformin medication. But it had not been updated to show it had been actioned. A dispenser confirmed they had carried out the necessary checks with no stock found. The pharmacy had medical waste bins and CD denaturing kits. And this supported the pharmacy team to manage pharmaceutical waste. The pharmacy had trained team members about valproate medication and the Pregnancy Prevention Programme for people at risk. And they knew to supply patient information leaflets and to provide cards with every supply. This included with supplies of multi-compartment compliance packs.

Team members had organised the dispensary to keep their working environment safe. The pharmacist positioned themselves so they could supervise the medicines counter. And team members worked at various workstations depending on the task they were carrying out. Dispensing baskets kept medicines and prescriptions safely contained during dispensing. And this managed the risk of items becoming mixed-up.

The pharmacy helped some people to manage their prescriptions. They re-ordered prescriptions on their behalf. And they kept them well-segregated from other types of prescriptions. The pharmacy dispensed serial prescriptions for a significant number of people that had registered with the 'medicines: care and review' service (MCR). And it had a system in place for managing dispensing. Team members retrieved prescriptions a week before they were due so they could order items in advance. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could check compliance. Team members dispensed multi-compartment compliance packs. And an online system helped them with the re-ordering of new prescriptions. They used supplementary records to check new prescriptions for accuracy. And they documented prescription changes which they retained alongside people's medication records. Descriptions of medicines were provided on dispensing labels. And team members supplied patient information leaflets for people to refer to.

The pharmacy sent around half of its prescriptions to an offsite hub for dispensing. These were mostly for people whose treatment was stable. The pharmacist checked prescriptions to make sure they were clinically appropriate. And they also checked that the prescription information had been inputted accurately before sending it to the hub for dispensing. Once assembled, the hub placed the medications in sealed prescription bags into separate orange totes and returned them to the pharmacy. Team members reconciled prescriptions with the items before placing them on the shelf for people to collect. And the pharmacist carried out clinical and accuracy checks when extra items were added by the pharmacy. Team members used an automated dispensing system for instalments of some medicines. And the pharmacist carried out a clinical check and an accuracy check at the time new prescriptions were entered onto the system. They carried out another accuracy check at the time of supply.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy used an automated dispensing system to dispense some medicine doses. And experienced team members calibrated the system each morning to ensure accuracy. The calibrations were recorded on template form and an audit trail was kept. The pharmacy provided blood pressure monitoring. And team members had attached an expiry date of March 2023 to the monitor. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

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.