General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Unit 38 Shandwick Square, Easterhouse Town Centre, GLASGOW, Lanarkshire, G34 9DT

Pharmacy reference: 1042354

Type of pharmacy: Community

Date of inspection: 14/01/2020

Pharmacy context

This is a community pharmacy located in a medium-sized shopping mall. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It offers a repeat prescription collection service and a medicines' delivery service. And it provides substance misuse services 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 blood pressure and diabetes testing and a smoking cessation service.

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	2.2	Good practice	The pharmacy team members complete regular training relevant to their roles. And the pharmacy provides time during the working day to support them to do so.
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 understand their role in protecting vulnerable people. And they 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 they listen to people and put things right when they can. Pharmacy team members record and discuss mistakes that happen whilst dispensing. And they use this information to learn and reduce the risk of further errors. They do not always collect detailed information about the causes of mistakes to help inform the changes they make. The pharmacy keeps the records it needs to by law. And it provides training for the team on how to keep confidential information. It has controls in place to keep people's private information secure.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The pharmacy employed an accuracy checking technician (ACT). And they knew only to check prescriptions that had been approved and annotated by the pharmacists. The company had defined the checking process in its working instructions. But it had not reviewed it since 2014 to show that ACTs followed current good practice. The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist and the accuracy checking technician (ACT) checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The non-pharmacist manager carried out weekly audits according to the company's requirements. And this provided assurance that the environment was safe and team members were up-to-date with training. The manager held a monthly briefing to discuss the audit findings. And to discuss any patterns and trends arising from the near-miss records. For example, the team members had agreed to improve near-miss recording due to a lack of records in October and November 2019. And record keeping had improved in December 2019 with more information provided about the possible causes of the errors.

The team members used 'look-alike and sound-alike' (LASA) labels to caution against selection errors. For example, they had highlighted prednisolone/propranolol products. The company had set a target to eliminate amitriptyline/amlodipine errors. And the team members had attached a LASA caution label to the shelves, and they had discussed the initiative to raise awareness. The team members kept up-to-date with safety information that the superintendent's office issued. For example, they had separated colchicine and cyclizine products. And they had agreed to always retain the original pack for the pharmacist or the 'accuracy checking technician' (ACT) to check against. The pharmacist managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, they knew about a recent incident when someone had complained that they had not been supplied with their weekly medication for over three weeks. The team members had discussed the incident. And they had arranged for the medication to be delivered and signed for instead of it being collected by carers on the person's behalf.

The pharmacy used a complaints policy to ensure that staff handled complaints in a consistent manner. But it had not dated the policy to show when it had been last reviewed and updated to meet

current requirements. The pharmacy invited people to provide feedback about its services. And the team members had noted that some people were dissatisfied with the time they waited for their prescriptions. The pharmacy team had agreed to provide realistic waiting times depending on how busy they were. And to annotate prescriptions with the time and date so they could adequately respond to negative feedback. The pharmacy had recently reviewed the prescription collection process. And they had introduced a mechanism, to prompt people to collect their prescription three weeks after it had been placed in the collections area. The new process had reduced the number of prescriptions on the shelves. And it had helped the team members to retrieve prescriptions in a timely manner and to minimise the risk of hand-out errors.

The pharmacy maintained the records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity insurance in place. And it was valid and up to date. The pharmacy team members kept the controlled drug registers up to date. And they carried out balance checks once a week. They carried out extra checks once a day to confirm that the methadone was correct. And to re-calculate the balance due to overages. The pharmacy team 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 (PGDs) to improve access to medicines and advice. And a sample showed that the trimethoprim PGD was valid until August 2020.

The pharmacy displayed a notice that informed people about its data protection arrangements. But this was not visible from the waiting area. The pharmacy regularly trained the team members to comply with its arrangements. And they knew how to safely process and protect personal information. The team members used designated bags to dispose of confidential waste. And they were regularly collected for off-site shredding. The team members archived spent records for the standard retention period.

The pharmacy displayed a chaperone notice beside the consultation room. And it used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The pharmacy had a safeguarding policy which included a list of key contacts. And this ensured the pharmacy team were able to make timely referrals if they needed to. The pharmacy provided the pharmacy team with regular safeguarding training. And they knew to refer concerns to the pharmacist when they recognised the signs and symptoms of abuse and neglect. For example, they contacted the community addictions team when they had concerns about the welfare of people.

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 they identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. It provides access to ongoing training and protected learning time in the work-place. The pharmacy team members support each other in their day-to-day work. And they can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy workload had remained stable over the past year. And the number of pharmacy team members had remained the same. The pharmacy replaced team members. And it had recently appointed a new team member to replace someone who had left. Most of the team members had worked at the pharmacy for a significant length of time. And they were experienced and knowledgeable in their roles. The pharmacy kept training qualifications on-site. And the following team members were in post; one full-time pharmacist, one full-time non-pharmacist manager (trainee pharmacy technician), one full-time pharmacy technician, an accuracy checking technician (ACT) providing support every Tuesday, one full-time dispenser, two part-time trainee dispensers, four part-time dispensers, one Saturday pharmacy student and one part-time driver. The pharmacy was experiencing a high level of unplanned absence at the time of the inspection. And it had arranged for two Saturday dispensers to work extra to provide cover. The pharmacy managed annual leave requests. And it maintained minimum levels by authorising only one medicines counter assistant and one dispenser to be off at the same time. The pharmacy manager used instant messaging to communicate with nearby branches. And this helped them to obtain support for unplanned absences.

The pharmacy supported all team members to develop and keep up-to-date in their roles. It provided mandatory training that supported the team members to comply with the company's governance arrangements. And when new initiatives were introduced such as the falsified medicines directive (FMD). The company tested the team members to confirm that the learning had been effective. And they had to achieve a pass mark of over 90% to do so. The new team member was making progress with formal training. And was being provided with 20 minutes of protected learning time each week to support her to do so. The trainee pharmacy technician was provided with more training time due to the level of commitment needed to complete the course.

The pharmacy manager carried out regular individual performance reviews to help the team members to improve and develop in their roles. For example, they had identified that three of the dispensers were interested in enrolling on the trainee pharmacy technician course. And they were supporting a team member to take more responsibility in their role. An ACT provided support every Tuesday. And they worked in another four branches throughout the week. The ACT kept records of their checking activities. And the pharmacist in each branch carried out weekly accuracy checks on 10 checked prescriptions. This provided ongoing assurance of competency in checking.

The company used targets to grow the services it provided. And the team members knew to identify

people that were suitable for the ‘chronic medication service’ (CMS). The team members did not feel undue pressure to meet the targets. And knew only to speak to people about services when it would benefit them. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had spoken to the pharmacy manager to ask if they could use an electronic system to manage repeat prescription requests. The manager had authorised the changeover from the paper system. And the change had made it easier for the team members to keep track of ordering and receiving new prescriptions from the surgery.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is 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 it provided patient information leaflets for self-selection. The pharmacy had allocated areas and benches for the different dispensing tasks. And the team members used benches in the centre of the dispensary to dispense and check 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 booth. And both areas were professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

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. 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 sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had step free access. And it provided unrestricted access for people with mobility difficulties. The pharmacy displayed leaflets in the waiting area. 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 team spoke to people about their medication. And the pharmacist and the manager identified people that would benefit from the chronic medication service (CMS). This allowed them to provide extra support or to refer them to other health care professionals if needed. The pharmacy had registered a significant number of people with its managed repeat prescription scheme. And this helped the team members to plan dispensing activities and to have prescriptions available in advance of them being needed.

The pharmacy team members used dispensing baskets. And they always kept prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 137 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 used separate benches to assemble and check the packs. And they used separate shelving in a rear area to store packs for delivery and packs for collection. The team members used supplementary records to support the dispensing process. And they updated them following prescription changes. The team members removed and isolated packs when they were notified about prescription changes. And they retained prescriptions alongside medication records. 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 to the pharmacist. The team members supplied patient information leaflets. And they provided descriptions of medicines. The accuracy checking technician (ACT) carried out final accuracy checks. And knew only to check prescriptions that the pharmacist had annotated. The pharmacy provided a delivery service to housebound and vulnerable people. And the delivery driver obtained signatures to confirm that people had received their medication.

The team members used a MethaMeasure to dispense methadone doses for around 40 people. And they sometimes obtained an accuracy check when they added new prescriptions to the system, but not on every occasion. The team members obtained a check at the time they made a supply. And this ensured they supplied doses that were in accordance with prescriptions.

The pharmacy purchased medicines and medical devices from recognised suppliers. The pharmacy kept most of its stock in a series of drawers. And kept the most commonly used products on shelves above the dispensing benches. The team members carried out regular stock management activities. And they

highlighted short dated stock and split-packs during regular checks. The pharmacy had two fridges. And it used one of the fridges exclusively for insulin products to manage the risk of selection errors. The team members monitored and recorded the fridge temperatures. And they 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 team members kept controlled drugs in four separate cabinets. And this managed the risk of selection errors, for example, they kept sugar-containing and sugar-free methadone in separate cabinets.

The team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome. For example, in December 2019 they had acted on an alert concerning ranitidine with no stock found. The pharmacy team members had been trained about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And they spoke to people that could be affected to confirm they knew about the risks. The company was in the process of providing training about the Falsified Medicines Directive (FMD) and what it aimed to achieve. But it had not yet introduced the system.

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). It used crown-stamped measuring equipment. And the measures for methadone were highlighted, so they were used exclusively for this purpose. The pharmacy used a MethaMeasure for dispensing methadone doses. And the team members kept records of the daily calibrations to show the machine was measuring accurate doses. The pharmacy team members had been trained to measure blood pressure. And they attached a dated label to show when they next needed to calibrate the monitor. The team members used a blood glucose monitor. And the manager confirmed they had been carrying out calibrations. But they were unable to produce the most recent records to demonstrate they had done so. The pharmacy kept 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 portable phones. 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.