General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 46 Brandon Parade East, MOTHERWELL, Lanarkshire, ML1 1LY

Pharmacy reference: 1042568

Type of pharmacy: Community

Date of inspection: 23/02/2023

Pharmacy context

This is a community pharmacy on a main street in the centre of Motherwell, a town on the outskirts of Glasgow. Its main activities are dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides a substance misuse service. It treats people for a variety of conditions under the NHS Pharmacy First Scheme and it delivers medication to people in their homes.

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

The pharmacy suitably identifies and manages the risks with its services. Team members appropriately reflect on any errors they make, and they make changes to improve working practices. They keep the records they need to by law. And they keep people's confidential information secure. They know what to do to help protect vulnerable adult and children in their community.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help guide the team to work safely and effectively. It had a process for team members to sign to confirm their compliance with the SOPs, but some signatures were omitted. The SOPs seen in the pharmacy were authorised for use by the superintendent (SI) pharmacist in July 2019 but there was no further confirmation that they had been updated or reviewed since. The pharmacist explained she was unaware if they had been updated by the company's head office. The folder was not well organised as it contained both current and out-of-date versions of the same SOP so team members may find it difficult to locate and follow an up-to-date version if required.

The pharmacy team members regularly recorded errors made and identified in the dispensing process known as near misses. Each team member was responsible for recording their own near misses and reflected on the potential cause. And learnings from near miss records were discussed amongst the team to help prevent any reoccurrence. Once a month, the trainee pharmacist reviewed the data to identify any trends and areas for improvement. And these were recorded under the company's patient safety review management process. He discussed the findings with team members and ensured that findings were communicated to team members not present. He explained that the most recent review identified that frequent errors occurred when selecting the incorrect form of a drug. And the team had implemented moving them onto separate shelves to minimise the risk of future incorrect selection of the medicine. They explained that previous selection errors involved medicines that looked-alike and sounded-alike (LASAs). To prevent this, they had implemented a process whereby the medicines were identified in the stock order and put into separate baskets by one team member before being put to shelf by a second team member, reducing the risk of these medicines being stored in the incorrect place. Team members explained that they had also used LASA and "caution" stickers throughout the dispensary as a visual aid to prompt careful selection of medicines. They reflected on and recorded learnings from errors identified after a person had received their medicines, known as dispensing incidents. Records showed that a recent incident had been investigated and a root cause analysis carried out. As a result, team members reviewed the SOP for handing out prescriptions and implemented warning stickers to alert team members to take extra care when handing out medication to people with similar names.

Team members had clearly defined roles and responsibilities. And they supported each other to complete tasks. They understood what could and could not be carried out in the absence of the responsible pharmacist (RP). They knew to telephone the area manager and inform the local NHS Health Board when the pharmacy was unable to open. The pharmacy had a contingency plan as the area manager was able to act as the responsible pharmacist (RP) so that people could receive their medicines. The RP notice was prominently displayed in the retail area and reflected the correct details of the pharmacist on duty. The pharmacy has current professional indemnity insurance.

The pharmacy had a complaints procedure which was displayed in the retail area. Team members explained complaints were usually resolved in the pharmacy by the pharmacist. But any that could not be resolved were referred to the superintendent (SI) pharmacist's team at head office. They provided people with the required contact information in the form of an email and telephone number. The pharmacist described how following feedback, the team had changed the procedure for delivery of medicines for a patient. Team members explained how they also received feedback via customer surveys.

The pharmacy kept its RP records electronically and from the sample seen, these were completed accurately. Records of private prescription supplies were kept on paper, and these were mostly from the company's online doctor service platform. The records had the necessary details, including the date of supply and the date the prescription was written. Prescriptions were kept by month in a folder for easy referencing. The pharmacy kept accurate records of special unlicensed medicines, which included the details of the person who prescribed the medicine and the person who received the medicine. The pharmacy kept paper records for controlled drugs (CDs) except for medicines supplied via an automated dispensing machine which were kept electronically. And from the sample seen, these complied with requirements. Team members carried out weekly checks of the CD stock against the register running balance. Random sampling of a selected medicine confirmed that the physical quantity matched the quantity in the register.

Team members were aware of their responsibilities regarding the General Data Protection Regulations (GDPR), and they were provided with annual company training. They had displayed notices prominently in the retail area which included information for patients regarding the GDPR and privacy policies. Team members kept confidential information separately for off-site destruction by a third-party company. They had undergone company training regarding their responsibilities for protecting vulnerable adults and safeguarding children. And this was supported by use of a SOP that they could refer to if necessary. And they displayed contact details of people they could contact for guidance if they had concerns, including those within the company and the local safeguarding teams. Team members explained they had good relationships with people accessing their services and gave an example of a person they had helped when they had not had contact with them as expected. They followed procedure and sought advice from the company's superintendent team and contacted another healthcare professional and the police to get the person appropriate care.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members who work well together to manage the workload. And they complete appropriate ongoing training to help develop them in their roles. They openly discuss any errors together, and they make suggestions to help improve the pharmacy's working practice.

Inspector's evidence

The pharmacy had a pharmacist manager, a trainee pharmacist, a pre-registration pharmacy technician, an accuracy checking technician and a medicines counter assistant working at the time of the inspection. Team members further included a dispenser who was the pharmacy's supervisor, a pharmacy technician, three dispensers and a delivery driver. The pharmacy consisted mostly of part-time team members, which helped the pharmacy cover holidays and team absences.

Team members were seen to be working safely and effectively together to complete tasks, and they were seen to be managing the workload. They were observed referring to the pharmacist and trainee pharmacist for advice, if necessary, when selling medicines over the counter. The pharmacist explained that team members regularly kept up to date with training relevant to their role and that three team members had recently completed accredited training courses to become dispensers. She explained that learning opportunities were communicated to team members by the company's online hub and the last training that had been issued was for a new patient medication record (PMR) system. The trainee pharmacist had trained team members to advise people about a new medicine, Gina, that was recently available for purchase without a prescription. The pharmacist explained that training material to support team member's conversations with people was kept in an organised folder at the medicines counter so they could easily refer to it if required. Team members had been trained to administer Naloxone to people who required it in a lifesaving emergency. And a team member had needed to utilise their training to assist a person shortly after they had completed the training. They were given protected learning time within the working day to keep their learning up to date. And they had most recently re-trained on the SOP for handing out medication to people after a dispensing incident had been reported.

Team members had regular conversations concerning any issues identified and they openly shared learnings about incidents that occurred. They felt comfortable making suggestions to improve working practices within the pharmacy, and they felt that this was due to the length of time they had worked together as a team. The pharmacist explained that she received appraisals from her line manager and that she had regular formal appraisals with the trainee pharmacist and pre-registration pharmacy technician as part of their ongoing training programmes. Team members explained that they felt comfortable raising concerns. And they knew who to raise them with.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, tidy, and well organised. There is sufficient space for the pharmacy's services. And the pharmacy has a suitable space where people can have private conversations with team members.

Inspector's evidence

The pharmacy was clean and tidy and free from clutter and trip hazards. The dispensary was spacious and there was adequate bench space for separating tasks safely and effectively. Medicines were kept neatly on shelves to minimise any selection errors. There was a sink in the dispensary which provided water for professional use. The pharmacy had an upstairs area that was used for storage and was accessed by a steep internal staircase, with a handrail to minimise risk of falls. And it had a kitchen and facilities for team members to have their breaks. The toilet facilities were hygienic and well maintained and there was a sink which provided hot and cold water for hand washing.

The dispensary was elevated so that team members could easily see people waiting to access services, and the pharmacist could intervene in conversations at the pharmacy counter if necessary. There was a semi-private area next to the pharmacy counter where supervision of medicines took place. The positioning of a wall ensured that people's privacy was maintained when this was in use. The spacious retail area of the premises had a soundproofed consultation room where people could have private conversations with team members. The room had space and facilities such as a desk, chairs, and a computer to allow the provision of services and private conversations. There was good lighting throughout the premises and the temperature was ambient.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services safely and effectively. And it stores its medicines as it should. Team members provide people with advice and information to help make sure they take their medicine safely. And they keep good records to ensure people receive their medicines when they need them.

Inspector's evidence

The pharmacy had a step free access to help provide ease of access for people, including those with limited mobility and those with pushchairs. Team members explained they could provide people who had some visual impairment with large print labels if necessary. The pharmacy provided a range of NHS Pharmacy First services including treatment for urinary tract infections, shingles, and impetigo. The pharmacist confirmed that she was trained and competent to provide the service and provided a signed document confirming this to the NHS Health Board. Team members supervised doses of medicines for people using an automated dispensing machine to measure doses. And they provided a busy needle exchange service where people could access safe equipment. Team members explained how they dispensed prescriptions from the company's online prescribing service. And there were safeguards in place to confirm suitability of treatment before the medication was dispensed. For example, the pharmacy team calculated a person's BMI before issuing weight loss injections to ensure that they were appropriately prescribed and suitable for the person. The pharmacist explained how the PMR system allowed team members to identify how often a medication had been issued by the online prescribing service, and this helped them to determine if the supply was suitable. And allowed the pharmacist to discuss with the prescriber who could take appropriate steps to manage the frequency of dispensing if necessary. The pharmacist administered vaccinations prescribed by the online prescribing service, such as hepatitis B vaccinations and human papillomavirus (HPV) vaccinations. And the pharmacy team also provided a blood pressure service and a diabetes testing service.

The pharmacy's main activity was to dispense NHS prescriptions. And it dispensed a large proportion of these into multi-compartment compliance packs to help people take their medicine safely. Each team member was trained to provide the service and the service was overseen and organised by the accuracy checking technician (ACT). The process was well organised, and each person had a designated folder which contained a chart that detailed which medication was taken and when. It also contained communications about any medication changes which were documented on a formal record, that team members had designed, to prompt them to capture all the relevant information. Team members ordered people's prescriptions two weeks in advance which allowed time to resolve any queries on prescriptions. And packs were completed a week before they were due. Packs for people who collected their medication were kept in the main dispensary and those for delivery were kept upstairs. Each person had a separate storage location for their packs to minimise selection errors. And these were marked with a colour to indicate the day that the pack was due to be collected. This helped team members to know if a person was collecting their pack on the correct day. The team provided patient information leaflets to people, and it put descriptions of the medicines on the pack to help people identify their medicines.

During dispensing, team members used baskets to keep prescriptions and medicines together so that they didn't become mixed up. And they initialled dispensing labels which provided an audit trail of who was involved in the dispensing process. They used stickers to highlight actions required by the

pharmacist or when there was a CD or fridge line to be handed out. Team members were aware of their additional responsibilities surrounding the dispensing of valproate to people in the at-risk group, explaining that they always issued people with the patient card. And the pharmacist explained that she knew the required conversation to have with people who were eligible, but they currently did not have anyone eligible.

The pharmacy provided a delivery service, taking medicines to people's homes. Team members identified people who received deliveries on the PMR system. And they could further highlight specific days for those who received multi-compartment compliance pack deliveries. People who received deliveries were asked to sign electronically to confirm they had received their delivery. And the pharmacy retained paper copies of signatures for delivery of controlled drugs so that any queries regarding delivery could be resolved.

The pharmacy kept pharmacy (P) medicines in the retail area in clear plastic boxes which were stored within sight of the pharmacy counter. Team members explained that people had previously selected medicines themselves. To prevent this, team members had turned the boxes round so that the opening was facing the wall and people were unable to select the medicines without assistance.

The pharmacy's fridges were kept neat and tidy. And records of daily fridge temperatures were kept. But one fridge had repeatedly recorded a slightly low temperature of 1.9 degrees, with no actions recorded. The pharmacist and ACT explained the temperature guage had been slightly increased and the pharmacist provided subsequent assurance of the temperature being within the recommended range. The pharmacy had a date checking rota which highlighted different areas of the dispensary to be checked on a weekly basis. And team members were up to date with the process. They highlighted any medicines with an expiry in the next six months with stickers so that they could be used first. Random sampling of several lines confirmed medicines were in date.

The pharmacy segregated patient returned medicines and these were disposed of appropriately. It kept its CD cabinets neat and tidy. And patient returned controlled drugs and out-of-date controlled drugs were kept separately to avoid becoming mixed up with routine stock. Team members pro-actively contacted the NHS Health Board to have the out-of-date CDs destroyed. The pharmacy received notifications about drug alerts and recalls via NHS mail or their communication hub. Team members explained how these were recorded electronically with appropriate action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs, and it generally completes regular checks to ensure it is suitable to use. It uses its equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to electronic copies of the British National Formulary (BNF) and BNFc (for children). The pharmacy used a blood pressure monitor which had been in use since July 2020 and was due to be replaced. Team members kept suitable records of calibration checks carried out for a blood glucose monitor and these were completed every twelve weeks. They kept suitable adrenaline kits within the consultation room to safeguard people who may have an anaphylactic reaction while receiving their vaccinations. And the adrenaline was seen to be in date. Team members used an automated system to measure methadone and they explained how it was calibrated daily and how this was checked for accuracy by the pharmacist.

The pharmacy had equipment for measuring liquids, and these were marked to identify which were used to measure liquid medicines and which were for water. There was a cordless telephone so that the team could have conversations in a private area of the pharmacy. Confidential information was kept secure by use of password protected computers which were positioned so that only authorised people could view the screens. Patient identifiable information on medicines awaiting collection was kept secure by positioning these behind a wall between the medicines counter and dispensary.

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.