General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 157 Nigel Rise, Dedridge, LIVINGSTON, West Lothian, EH54 6LX

Pharmacy reference: 1043074

Type of pharmacy: Community

Date of inspection: 10/06/2021

Pharmacy context

This is a community pharmacy close to a GP practice in a residential area. 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 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 services including smoking cessation, blood pressure measurement and diabetes testing. This pharmacy was inspected during the COVID-19 pandemic.

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	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 identifies and manages the risks with its services well. This includes managing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records it is required to by law and keeps people's private information safe. Team members know who to contact when they have concerns about vulnerable people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter and hand sanitiser available. The pharmacy had marked the floor to encourage people to socially distance. It limited how many people were on the premises at any time to enable social distancing. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. A team member cleaned the consultation room immediately after use. The pharmacy had carried out a personal risk assessment with each team member early in the pandemic to identify any risk that may need to be mitigated in the pharmacy. No such risks had been identified. Some team members carried out lateral flow Covid tests sometimes.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them at least every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and confirmed on individual record cards. Team members could describe their roles and dispensers were all competent to undertake all tasks, which they did in rotation. They accurately explained 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 pharmacist signed prescriptions that she had clinically checked to enable an accuracy checking pharmacy technician (ACT) to carry out the final accuracy check. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. And it had the phone number to call if the pharmacist was late or did not turn up highly visible in the staff area. Team members knew to call this number and/or the area manager as soon as possible to minimise disruption to services.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. They recorded potential reasons for mistakes such as making assumptions on the form of medication. They recorded 'no near misses' on days when there had been none, demonstrating that recording and learning from these was in their minds. And they recorded errors that had been identified after people received their medicines, although there had been none recently. They reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. Changes made following incident review included attaching labels to drawers to highlight certain items, and separating strengths of tablets involved in errors. The pharmacy had identified staff absence as a contributing factor and had recorded calling other local branches to ask for help. Unfortunately, other branches were not able to release

anyone in that instance. The pharmacy also carried out other audits and checklists with different topics audited each week on a monthly cycle. These were recorded and discussed at weekly meetings. The pharmacy had a complaints procedure and welcomed feedback. Team members were not able to recall any complaints, but several 'thank-you' cards were observed in the pharmacy from satisfied people. And a person using the pharmacy at the time of inspection told the inspector about the greatly improved service he had received over the past few months.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2021. The pharmacy displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. Team members took turns to do this. It had a CD destruction register for patient returned medicines. This showed that the team destroyed patient-returned items regularly and these did not accumulate. There was one item recorded and observed at the time of inspection. Team members signed any alterations to records, so they were attributable. All records were accurate and up to date.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed company policies. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The delivery driver described several examples of contacting the GP practice and discussing concerns for people with the pharmacist. The pharmacy had a chaperone policy in place and displayed a notice telling people this. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They regularly complete training and they are competent for their roles and the services they provide. The pharmacy gives them time during the working day for learning and development. Team members make appropriate decisions within their competence to provide safe and efficient services to people. And they use their professional judgement to help people, including when speaking to other healthcare providers. They know how to make suggestions and raise concerns if they have any to help keep the pharmacy's services safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one part-time (one day per week) accuracy checking pharmacy technician (ACT), three full-time dispensers, and one part-time medicines counter assistant who worked mornings, and a delivery driver shared with other branches. The pharmacy displayed team members' certificates of qualification and competence in service delivery. Typically, there were three or four team members including the pharmacist working at most times. Team members were able to manage the workload but described challenges when there was absence reducing this level. They explained that they were currently trying to get ahead with routine dispensing as there was a known period of absence coming up.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development including online modules prescribed by the company and reading different SOPs each month to keep their knowledge fresh. And it provided team members undertaking accredited courses with additional time to complete coursework. Two dispensers had completed their training during the pandemic and described the benefits of working together and learning from one another.

Team members were observed going about their tasks in a systematic and professional manner. During the inspection the team identified a prescribing error. A dispenser was observed to communicate with the surgery in a very assertive and professional manner. This ensured the pharmacy supplied the correct medication safely and had the required documentation from the prescriber to provide a complete audit trail of medication started and stopped. Team members asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

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 or area manager and the area manager's phone number was on a whiteboard for ease of access. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. The pharmacy had these in a file on the wall and team members read and signed these. The pharmacy team discussed incidents and how to reduce risks at their weekly 'safer care' meetings. It kept notes of these meetings, recording team members present. One team member kept a notebook describing processes and how to access various computer systems. This was a useful

aide memoire for herself and she shared it with colleagues and locum pharmacists. It helped others complete processes that they were not familiar with, in a safe and efficient way. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for the services it provides. The pharmacy has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and a back area including storage space and staff facilities. The premises were clean, hygienic and well maintained. Team members cleaned surfaces and touch points more often than before the pandemic. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available for them to use in several locations in the dispensary.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and computer which was clean and tidy, and the door closed providing privacy. This room was just large enough for social distancing and this was managed by positioning of chairs. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy effectively helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and 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. Pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a ramp at the entrance and team members helped people with the door if required. It listed its services and had leaflets available on a variety of topics. It displayed information about the 'Ask for ANI' (action needed immediately) initiative for victims of domestic abuse. Team members signposted people to services that may help them such as drug and alcohol services and other needle exchange providers. The pharmacy displayed this information in the consultation room where it was seen by people who may find it helpful. All team members wore badges showing their name and role. The pharmacy provided a delivery service which had been used more during the pandemic. The delivery driver was very experienced.

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. They labelled prescriptions as soon as possible after receipt. And brought any changes to the pharmacist's attention to support her clinical checking process. The team arranged prescriptions alphabetically to help locate them quickly if people were looking for their medicines before the pharmacy had completed the dispensing process. Team members usually dispensed medicines the following day then they were checked by the pharmacist and placed on the retrieval shelves. The shelves were arranged and labelled by day and week number as part of a four-week cycle. Each day a team member removed any items still on the shelf from the previous cycle. This ensured that the shelves did not become cluttered and identified people who had not collected their medicines. A team member contacted people before this point, so if medicines were removed, they were no longer needed. Team members placed the medicines back into stock if it was appropriate to do so, updated the person's medication record and amended the electronic endorsement. This ensured records were accurate and the pharmacy was not paid for medicines not supplied. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. Currently they were a few days ahead, planning for known absence. They kept comprehensive records following the SOP and using the company's paperwork. Team members only made changes to medication on receipt of a valid prescription and a change form signed by the prescriber. This was required for new items and items being stopped to ensure an accurate and complete audit trail. The relief ACT carried out the accuracy checks on these packs one day per week. There was a clear process in place that identified packs to be

checked. Team members then moved these into named boxes arranged and labelled with day and method of supply. They clearly labelled the compliance packs with the date of supply. And they firmly attached backing sheets which included tablet descriptions. Multiple backing sheets were easy to read. The pharmacy supplied patient information leaflets with the first pack of each prescription. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed some of these prescriptions in their entirety when the pharmacy received them. And they dispensed others weekly, supplying some liquids in individual daily bottles even when a week's supply was provided. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were stored alphabetically in individually named baskets. Team members dispensed some instalments using a 'Methameasure' pump device when people presented at the pharmacy. The pharmacy had a robust process in place to ensure it supplied additional medicines with these.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She 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. The pharmacy did not supply valproate to anyone in this group. Team members knew where information to be supplied to people was kept and had posters and information on notice boards in the staff area. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary which was accessible in the dispensary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. During the pandemic the pharmacist had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. The pharmacist tested people for diabetes and measured people's blood pressure if they requested these services. Other team members were not trained in these yet. But currently there was little demand. One dispenser was trained and competent to provide the smoking cessation service. All team members were trained and competent to provide the needle exchange service. They provided this in the consultation room where they made the necessary records. They encouraged people to return used equipment when appropriate.

The pharmacy obtained medicines from licensed wholesalers such as AAH and Alliance. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items and obsolete items. The pharmacy stored items requiring cold storage in three fridges and team members monitored and recorded minimum and maximum temperatures daily. They 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 Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety 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. Team members look after this equipment to ensure it works.

Inspector's evidence

The pharmacy had resources 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 replaced as per the manufacturer's guidance, and blood testing equipment calibrated as per guidance. The team was not using some of this equipment during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped and ISO marked measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets. The pharmacy had a 'Methameasure' pump device. Team members cleaned it daily after use and poured test volumes each morning as part of their set-up process to ensure it was working accurately.

The pharmacy stored paper records in the dispensary and office areas 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 in the retail area. Team members used passwords to access computers and did not leave 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.