General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 2 Ferryburn, SOUTH QUEENSFERRY, West Lothian, EH30 9QS

Pharmacy reference: 1088912

Type of pharmacy: Community

Date of inspection: 03/10/2019

Pharmacy context

This is a community pharmacy in a residential area of a small town. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services. And it is starting flu vaccination for the season. And has recently started 'Vitality' health checks.

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	1.2	Good practice	The team record all errors and review them to avoid the same thing happening again. And all team members make suggestions to reduce errors and improve safety.
2. Staff	Standards met	2.1	Good practice	The pharmacy reviews staffing levels and makes changes to safely manage the workload.
		2.2	Good practice	The pharmacy provides training material that reflects the needs of the individual and the pharmacy. And protected learning time for team members to use this to ensure services are safely delivered.
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 follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. And they review these and make changes to avoid the same mistake happening again. The pharmacy uses people's feedback to make pharmacy services better. It keeps all the records that it needs to by law and keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and confirmed on staff competency records. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They were all aware which colleagues could not deliver some services until they had been fully vaccinated against hepatits B. 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 pharmacy had a business continuity plan to address maintenance issues or disruption to services. It had a 'one-call' menu providing team members with contact details.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They explained that they recorded all errors at the time they were identified. If a pharmacist identified an error on a team member's day off, she left it aside for the team member to review and record the following day. Some days no incidents were recorded, and the pharmacist explained that this was correct. The team recorded all errors and dispensing was usually very accurate. Team members used a safer care board to display documents for all to read. They recorded how many days it had been since the last error on this board. They used adhesive notes with safer care suggestions or topics to be discussed and placed them on this board. They discussed these at their monthly meetings and kept them in a safer care folder along with meeting notes. A recent example was a team member suggesting a refresher training on valproate, which had occurred. The team also recorded errors reaching patients to learn from them, although these were very rare. Team members reviewed all near misses and errors each month and introduced strategies such as separating items involved to minimise the same error happening again. The pharmacy carried out weekly safer care audits covering different aspects of service delivery. Team members discussed these at monthly meetings.

The pharmacy had a complaints procedure and welcomed feedback. It had recently received a few comments and complaints about prescriptions for multi-compartmental compliance packs from another branch being relocated for processing to this branch without people being told. Team members apologised to people and notified the other pharmacy, suggesting that it should obtain people's consent before moving their prescriptions.

The pharmacy had an indemnity insurance certificate, expiring 30 June 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members always recorded

these on receipt, and usually destroyed them at that time as there was limited space in the CD cabinet. A team member had obliterated an entry in a CD register three months previously, making it difficult to read what the correction was. Legislation required that entries were not obliterated but altered by a footnote. Team members signed any alterations to records, so they were attributable. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and undertaken annual training. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also undertaken annual training on safeguarding. They knew how to raise a concern. The pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is and then makes changes when required. This ensures skilled and qualified staff provide pharmacy services. Team members have access to training material to ensure that they have the skills they need. And the pharmacy gives them time during the working day to do this training. Pharmacy team members make decisions and use their professional judgement to help people. Team members can share information and make suggestions to improve services and keep the pharmacy safe. They discuss incidents and learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: 0ne part-time pharmacist manager three days per week and one regular pharmacist two days per week; one part-time (21 hours per week) pharmacy technician; two part-time dispensers, one part-time medicines counter assistant who was also the supervisor; one Saturday only medicines counter assistant and a part-time delivery driver. The pharmacy displayed their certificates of qualification. Typically, there were three team members including the pharmacist working at most times. The pharmacy had recently reviewed staffing levels and work patterns and some changes were being introduced. The medicines counter assistant (supervisor) and pharmacy technician were reducing hours and the Saturday only medicines counter assistant was changing to cover these hours. So' the pharmacy was recruiting for a new Saturday team member and interviews were planned. The pharmacy manager worked alternate Saturdays and a locum pharmacist worked the other Saturdays. The pharmacy was planning for a regular team member to work on Saturdays with the locum and new team member. The team was able to manage the workload and team members worked flexibly to cover absence. The pharmacists and pharmacy technician had worked in the pharmacy for many years, and the dispensers for a few years so the team was very stable.

The pharmacy provided protected learning time for all team members to undertake regular training and development. They undertook regular monthly modules ('mylearn'), mandatory training including confidentiality and health and safety, and other topics as required. A recent example was vaping products All team members had recently received training on the 'Vitality' health checks. The pharmacist and pharmacy technician described what stage they were at with revalidation. Team members had annual development meetings with the pharmacy manager to identify their learning needs. They had development plans in place and objectives included considering NVQ 3 training. The two pharmacists met regularly to share information and discuss issues and a variety of topics within the pharmacy. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacist described several interventions and discussions with prescribers. One example was related to analgesics been prescribed too frequently. This was appropriately addressed.

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, and this was demonstrated following a dispensing error. Team members felt

able to raise concerns with the manager or area manager and gave appropriate responses to scenarios posed. The company had a whistleblowing policy that team members were aware of. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team members read this document ('daily dose') and signed to acknowledge this. The described separating and moving some items following incident elsewhere in the organisation e.g. olanzapine. The pharmacy team discussed incidents and how to reduce risks. Team members had regular monthly meetings. They kept notes of these meetings and had a process in place for sharing information with colleagues who were not present. The company set targets for various parameters. The team members explained that they used these to remind them to offer services to people who would benefit.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. All team members used this room with people for quiet conversations. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly.

Inspector's evidence

The pharmacy had steps and handrails at the entrance. Team members helped people as required. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and could provide large print labels. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines. One of the pharmacists was an independent prescriber working in the GP practice with people with chronic obstructive pulmonary disease (COPD). She provided information and education to people both in the surgery and in the pharmacy and made some treatment interventions.

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 used dedicated areas for labelling, dispensing and checking prescriptions. Team members highlighted new medicines or changes to the pharmacist who used this information with the patient medication record (PMR) when checking. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines.

The pharmacy usually assembled owings the following day in the morning when stock was received, using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these before the expected supply date. Team members kept thorough records of date of dispensing and supply. They kept the records with dispensed medicines until they had been collected. Then they completed the record and filed it. The pharmacist had no concerns about people's compliance with their medicines, but this process would identify any issues. The pharmacy was actively registering people for this service. The pharmacists used appropriate questioning depending on people's medication to identify issues or side effects. They discussed smoking status, alcohol consumption and measured blood pressure as part of CMS reviews. They had agreed this with the local GPs. Examples were described of identifying high blood pressure and referring people urgently to their GP. The pharmacist sometimes identified pharmaceutical care issues when discussing people's medicines with them. These included side effects such as dry coughs with a particular medication.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. The team kept thorough records including progress logs and records of who had dispensed and checked all packs. Prescribers used a template to notify the pharmacy of any changes and these were kept with people's records. Team members included tablet descriptions on backing sheets and all packs were labelled with instalment number and date of supply. They stored completed packs in individual boxes labelled for each person. And they supplied patient information leaflets (PILs) each month. The pharmacy sent some of these prescriptions to an off-site hub for assembly. This process had recently been changed and all team members had read the SOP and were following it. A few people received four packs at a time despite prescriptions saying, 'dispense weekly'. The

pharmacist had assessed these people for suitability and safety, but there was no evidence of prescriber involvement.

Team members followed a timetable which built in time for monthly tasks and administration as well as the assembly of packs. They spent mornings dealing with stock and assembling balances as the medicines' delivery arrived early in the morning. And they spent afternoons dispensing collection service prescriptions and assembling multi-compartmental compliance packs. A team member collected prescriptions from the GP practice at lunchtime. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these the previous day and a pharmacist checked them and stored them in labelled bags in a designated area.

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 stored the information pack beside tablets. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately. Team members had recently revisited the information to ensure it was fresh. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, supply of chloramphenicol ophthalmic products and chlamydia treatment. It also followed private PGDs for flu vaccination and 'Vitality' health checks. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence, under a pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required.

The pharmacy was starting seasonal flu vaccinations the following week and both pharmacists were trained and following PGDs. All team members were trained and competent to measure blood pressure. They checked all results with the pharmacist while the person was still in the pharmacy. The pharmacy sometimes lent people a blood pressure meter to check their own blood pressure daily for a week. A team member showed people how to use the meter and complete the paperwork. The pharmacy had agreed this process with the local GP practice and provided people with the same paperwork as the GP practice used. A person returned a meter to the pharmacy during the inspection. The pharmacy had recently introduced 'Vitality' health checks which were popular with several appointments each week. All team members were trained to deliver this service, but one dispenser was not fully vaccinated yet. So, she did not deliver this service currently. Team members measured people's height, weight, blood pressure, cholesterol and blood sugar as part of this service. They also determined people's smoking status and referred them to the smoking cessation service if appropriate. They followed a PGD and results were discussed with the pharmacist and referred to a doctor if necessary.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). The pharmacy had the equipment on site, but team members had not yet received training. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken 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 MHRA recalls and 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 texts 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, and a blood pressure meter which was replaced as per the manufacturer's recommendation. The pharmacy team had labelled it with the date of first use. The pharmacy had recently obtained equipment for delivering 'Vitality' health checks. Team members stored this in its original case in the consultation room. And they calibrated it as recommended and kept records. They kept two sets of anaphylaxis equipment in labelled baskets in cupboards in the consultation room. They labelled one for flu vaccination use, to prevent the adrenaline injections being supplied on prescription. And they kept sundries required for services including alcohol hand gel, gloves and sterile wipes in the same way. Team members kept crown stamped 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 stored paper records in locked cupboards in the consultation room and in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left 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.