General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Unit 6, Block 1, Turnstone Road, DUNFERMLINE, Fife, KY11 8JZ

Pharmacy reference: 1093642

Type of pharmacy: Community

Date of inspection: 12/08/2019

Pharmacy context

This is a community pharmacy in a modern residential area beside other shops and a large supermarket. People of all ages use the pharmacy. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs.

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	2.3	Good practice	The pharmacy team can give examples of interventions that have had positive outcomes for patients. Some were observed during the inspection.
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 processes for all services to ensure that they are safe. They read new or updated procedures when they receive them. Pharmacy team members record mistakes to learn from them. They review these and make changes to avoid the same mistake happening again. The pharmacy asks people for feedback and team members discuss this to make pharmacy services better. The pharmacy 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 supervisor/dispenser confirmed the inspector's identity by phoning the GPhC then her cluster manager to ensure the person was an inspector before allowing access to the dispensary. The pharmacy had standard operating procedures (SOPs) which were followed for all activities/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. Each team member had a competency sheet confirming activities that they were competent at and following the SOP. They were working through a new SOP recently received in the pharmacy. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The supervisor/dispenser and a pharmacy technician had additional responsibilities e.g. safer care reviews and audits and pharmacy paperwork including counting and documenting prescriptions. 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' with the number to be phoned for any issues, and a list of other useful phone numbers.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They explained that some locum pharmacists did not tell them when a mistake was made so some may not be recorded. (The pharmacy did not have a regular pharmacist and the responsible pharmacist record showed a lot of different pharmacists over the past few months.) Team members also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. They also undertook safer care audits each week and action plans following these were on a board in the dispensary. Team members discussed these and were always reminded to document all near misses or errors. They were also reminded not to rush and be mindful of locum pharmacists' different ways of working. This meant that team members had to be flexible in their ways of working. The pharmacy also carried out other audits including auditing people taking valproate. A team member explained this audit was due, but they could not do it until there was a permanent pharmacist, or continuity over a two-week period.

The pharmacy had a complaints procedure and welcomed feedback. A team member explained that some people found the entrance door to the pharmacy heavy and difficult to use. She was going to order 'Push' and 'Pull' signage to assist, as some people tried to move the door in the wrong direction. Team members helped people when they were having difficulty.

The pharmacy had an indemnity insurance certificate, expiring 31 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 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. The pharmacy dispensed a lot of private prescriptions as it had a Ministry of Defence (MoD) contract – prescriptions were received daily. Some of these, and online doctor records were incomplete (e.g. no prescriber name) so they did not comply with legislation.

Pharmacy team members were aware of the need for confidentiality. They had all read an SOP. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read information on safeguarding. The pharmacy had a safeguarding folder containing information/guidance and the process to be followed when raising concerns. It had records of team members reading it. The delivery driver described several examples when he had concerns for people. He had dealt with these in a variety of ways, including calling an ambulance and waiting with the person, contacting relatives and describing situations to the pharmacist who contacted the person's GP. The pharmacist was PVG registered. Other examples were described including the pharmacy playing its part in people moving to supported accommodation.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide services most of the time. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Pharmacy team members make decisions and use their professional judgement to help people. They refer to other healthcare professionals or adapt services to address the needs of individuals. Team members can share information and raise concerns to keep the pharmacy safe. The pharmacy team members discuss incidents that have occurred in this pharmacy and the wider organisation. They learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist equivalent (locum/relief pharmacists); one part-time (four mornings) pharmacy technician; 1 full-time supervisor/dispenser; two part-time dispensers; one part-time medicines counter assistant (mornings), one Saturday only assistant and a part-time delivery driver. The pharmacy displayed their certificates of qualification in the consultation room. At the time of inspection there was a relief pharmacist, the pharmacy technician for part of the time, a dispenser for part of the time and the supervisor/dispenser. The pharmacist left in March, five months previously and the pharmacy had several different locum pharmacists since then. Team members could manage the workload, but it was challenging. The pharmacy had become busier over the past two years as the local population increased. There was a school close by, which resulted in a lot of pharmacist consultations and requests for the minor ailments service. Locum pharmacists commented on that service being busier in this pharmacy than others. The local GP practice expected people to take advice from the pharmacist for some conditions before making a GP appointment. A team member explained that the pharmacy staffing was reviewed about three years ago and there had been a slight loss of seven hours per week.

The pharmacy provided protected learning time for team members undertaking accredited courses. And for all team members to undertake regular monthly training on a variety of topics which had recently included Ella One and the Falsified medicines directive (FMD). It kept records of some training in the safer care folder e.g. reading SOPs, and new services such as the Vitality heath check which had recently started. The area coach had come to the pharmacy and trained some team members to deliver this. Team members had development meetings about every 18 months with the pharmacy manager. They had not had these recently as there was no pharmacy manager. The previous one had issued preparatory paperwork to the team before leaving. 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. Several examples were observed of exemplary consultations with people. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The team members present had most professional and caring attitudes towards people.

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 supervisor, locum pharmacists or cluster manager. The pharmacy had contact details for the NHS controlled drug accountable officer and the GPhC inspector accessible. Team members described the type of incident

they would share. 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 and signed to acknowledge this. The pharmacy team discussed incidents and how to reduce risks. The team members had regular meetings focussing on safer care and they documented who attended and took notes. Recently they had discussed how to manage short staffed periods, similar sounding or looking medicines, and the challenges of different ways of working with different pharmacists. They had noted that they were not managing to maintain the pharmacy to their usual standards. They felt it was untidier than usual and were trying to tidy as they worked. The pharmacy was not untidy during the inspection. The company set targets for various parameters, but team members explained that these did not have a negative impact on people. They explained that they only offered services to people who would benefit.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for its services. The pharmacy team members use a private room for some conversations with people. People cannot overhear private conversations. The pharmacy protects patient information. The pharmacy is secure when closed. The pharmacy team members raise concerns if there is damage to the premises or fittings. The pharmacy addresses these.

Inspector's evidence

These were reasonably sized modern premises incorporating a retail area, dispensary and back shop area including storage and staff facilities. The premises were clean, hygienic and well maintained. The toilet was not working properly, so team members had raised this with the maintenance department and repair was underway during the inspection. The contractor explained to the supervisor that he would return later in the week to complete the repair. 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. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. 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 as appropriate. The door was kept locked to prevent unauthorised access. 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. The pharmacy team know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and a wide door. Some people found the door difficult to use but team members assisted as required. The pharmacy had a sign on the door welcoming assistance dogs and advertised that a hearing loop was available. It listed its services and had leaflets available on a variety of topics. 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. The driver did not have a fridge in his vehicle but delivered items requiring cold storage first. He delivered prescription medicine to a military base. These were packs for individual patients then sealed in a box. The driver waited at the base while the box was unsealed, and all items were checked off in front of him.

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. The pharmacy had distinct dispensing and checking benches. Three team members worked most mornings – one worked on collection service prescriptions, one on walk-in prescriptions then MOD descriptions, and another team member worked on multi-compartmental compliance packs in an area at the rear of the dispensary. They used labels to highlight high-risk items and those requiring storage in a fridge or CD cabinet and provided notes for the pharmacist about any changes to medication. Practice pharmacists were involved in a lot of the prescribing and provided additional information on or with prescriptions. 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 multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members followed a very robust and organised process and kept thorough records. They had the SOP and additional detail of the process accessible in this area for all to follow. The pharmacy technician managed this activity most of the time, but others were competent to deputise in her absence. Team members used a notebook to share information with each other. They were assembling packs this week for supply the following week. The pharmacist sealed trays at the point of checking and packaging was left to facilitate the check. Some people were supplied with four packs at a time despite prescriptions stating, 'dispense weekly'. This was historic, and the pharmacy technician explained that a locum pharmacist had pointed out that this should not be happening, so she was in the process of changing people to weekly supply. Some instalment prescriptions for controlled drugs did not comply with legislation as they did not include instalment amount. Team members printed tablet descriptions on backing sheets, but some were very basic e.g. 'round white tablets' so did not identify individual tablets. They attached backing sheets firmly and neatly to packs and supplied patient information leaflets monthly. The pharmacy stored completed packs on clearly labelled shelves in the same area as they were assembled. People signed to acknowledge receipt of their medicines.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high risk medicines including valproate, methotrexate, lithium, and warfarin. A team member supplied written information and record books if required. The pharmacy had put the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the previous permanent pharmacist had counselled them appropriately. As noted elsewhere, the pharmacy was due to re-do this audit that could not do so until there was some continuity of pharmacist. 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, and chloramphenicol ophthalmic products. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They used a template to gather information, and this stayed with prescription until the medicine had been supplied. The pharmacy sometimes retained these templates as evidence of frequency of supply. Surgeries encouraged people to go to the pharmacy initially with symptoms. All team members used the consultation room appropriately with people. They referred to the pharmacist as required – this was observed. The pharmacy had recently introduced the new vitality health check service. As noted elsewhere several team members had been trained to deliver this and new equipment was available that they knew how to use.

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). Team members were fully aware of this legislation and had undertaken training. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It kept methotrexate tablets on a separate shelf with a marked tablet counter and tweezers. 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. Waste including medicines was well segregated with information on the wall. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. The inspector observed good use of protocol questioning in very natural way while showing potentially suitable products.

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

Pharmacy has the equipment it needs for the delivery of its services. The pharmacy looks 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, a blood pressure meter which was replaced every two years as per the manufacturer's guidance, and blood testing equipment calibrated as per guidance. This equipment was new so had not yet been recalibrated, but team members knew how to do this and had the resources. Team members kept Crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. They also had clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and cupboards in the consultation room inaccessible to the public. Team members used passwords to access computers and never left them unattended and lace 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.