General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 157 Duff Street, MACDUFF, Banffshire, AB44 1PS

Pharmacy reference: 1106305

Type of pharmacy: Community

Date of inspection: 04/09/2019

Pharmacy context

This is a community pharmacy in a residential area. 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. It offers extra services including travel vaccination and seasonal flu vaccination.

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 pharmacy records and reviews all errors. Team members reflect on these and learn from them.
		1.8	Good practice	The pharmacy team makes appropriate safeguarding interventions and records actions taken.
2. Staff	Standards met	2.2	Good practice	The pharmacy encourages learning and development, providing time and resources. Team members undertake training relevant to the pharmacy's services.
		2.3	Good practice	The pharmacy makes and records interventions that have positive outcomes for people.
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. They review these and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. 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 individual records of competence. Team members could describe their roles and accurately explain 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 pharmacy had a business continuity plan to address maintenance issues or disruption to services including a 'one-call menu' with the appropriate contact number.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them although there had been none recently. They reviewed all near misses and errors each month and introduced strategies to minimise the same error happening again. They had noted that sometimes fatigue contributed to errors, so team members were encouraged to take a short break when this was recognised. Team members took turns at being the 'safer care champion', giving them all a chance to review error data and discuss with the whole team. The recent review had identified training requirements which were being addressed and highlighted that sometimes greater concentration and less 'chat' was required.
The pharmacy carried out weekly safer care audits on different themes to identify any areas for improvement. It kept records of team briefings including people present, case studies discussed, recent incidents and other topical issues such as the re-classification to schedule 3 controlled drugs.

The pharmacy had a complaints procedure and welcomed feedback. The pharmacy had an indemnity insurance certificate, expiring 30 April 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.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and undertook 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 had access to contact details and processes. 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 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. The pharmacy gives them time to do this training. Pharmacy team members make decisions and use their professional judgement to help people. They discuss incidents. And they learn from them to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one full-time and one part-time pharmacy technicians, four part-time dispensers and a part-time delivery driver. A Saturday only pharmacy assistant had recently left, and the pharmacy was recruiting with interviews planned. All team members were helping to cover Saturdays currently. The part-time pharmacy technician was also a supervisor. The pharmacy displayed their certificates of qualification. Typically, there were 3 team members and a pharmacist working at most times, and two with a pharmacist on Saturdays. The pharmacy used a rota to ensure all team members worked on the medicines counter. They each worked on the counter for a half-day for a week at a time. Team members were able to manage the workload. And part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided protected learning time for all team members to undertake regular training and development. This included regular monthly electronic modules and ad-hoc modules. Recent examples were Ellaone, vaping and the requirements of the falsified medicines directive (FMD). Team members had access to disease specific modules e.g. diabetes and pain. They had all completed a module on the risks associated with valproate. Team members were required to undertake mandatory training regularly including information governance, safeguarding, pharmacovigilance, and processes for the company dispensing support pharmacy.

They had annual development meetings with the pharmacy manager to identify their learning needs. And they had development plans in place with objectives including increasing the number of blood pressure measurements and diabetes screenings undertaken to embed learning. 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 and other team members recorded interventions and provided a copy to other health care professionals if appropriate. Examples included contacting the local care manager and getting a person set up on the medicines' management service; arranging prescriptions to be changed to a branded inhaler and spacer device when a person was unable to use a metered dose inhaler; assessing a person for, and then arranging prescriptions for multi-compartmental compliance packs following several changes to medication; and getting a person's consent to discuss medication with a friend to help them manage their medicines.

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. The pharmacy had access to case studies electronically which they used for discussion at monthly meetings. The topic currently was ‘interventions’ which the team had discussed and noted that team members were already doing this effectively. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members described how they used these as a reminder 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. 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 small back shop area including minimal 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. 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 good physical access by means of a level entrance and power assisted automatic door. 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. Team members re-packed tablets into bottles for a person who could not manage blister packaging. 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 was never away from the pharmacy for long periods and delivered items requiring cold storage first to minimise the time they were out of the fridge.

A GP surgery that had been close to the pharmacy closed a few months ago which had affected dispensing workload as there were now fewer walk-in prescriptions. The pharmacy received prescriptions from a GP practice in a nearby town. 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. When team members noticed changes to people's medication they highlighted this to the pharmacist verbally or using a note. They used dedicated areas to dispense different types of prescription e.g. multi-compartmental compliance packs, collection service prescriptions and walk in prescriptions. The pharmacist's checking bench overlooked the medicines counter helping her to supervise sales of pharmacy medicines. 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 using a documented owings system. A team member undertook this task early in the day after the order had been received and put away. Another team member assembled and managed multi-compartmental packs in mornings.

The pharmacy received few walk-in prescriptions since the surgery had moved. Team members undertook planned dispensing in mornings then dispensed collection service prescriptions in the afternoons. One person labelled while one dispensed, or if the pharmacist had a lot of items to check, both team members labelled to avoid an excessive number of items waiting to be checked. Some people received medicines from chronic medication service (CMS) serial prescriptions. The pharmacy dispensed these before patients presented. Team members kept a printed list of when next instalments were due, and recorded collection dates. Occasionally medicines remained on retrieval shelves for up to four weeks. Team members discussed compliance concerns with prescribers. Most people receiving serial prescriptions had previously used the pharmacy's managed repeat service. So, they did not see any change to the supply function and were familiar with the routine.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members did this in mornings, around two weeks before the first pack was required. They followed a systematic process including checking prescriptions against templates, gathering stock before labelling to ensure tablet descriptions were correct and having split packs checked. They left full packs with the prescription and dispensed medicines to facilitate the final

accuracy check. The pharmacist sealed packs when checking. Team members added unstable medicines on the day of supply. They dispensed and labelled these in entirety and stored them with the compliance pack to ensure availability. They stored completed packs on dedicated labelled shelves. The pharmacy kept comprehensive records including a chronological list of interventions and changes with prescriber details. Team members included tablet descriptions on packaging and 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 these in entirety on receipt, and the medicines were stored in individual labelled bags in separate baskets on dedicated shelves. Some but not all were marked with the date of supply. Team members did this for people collecting daily and others known to be confused.

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 and the pharmacist had counselled them appropriately and discussed with the GP. The pharmacist agreed to provide monthly counselling and information to certain people in the 'at-risk' group.

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 supply of chloramphenicol ophthalmic products. It also followed private PGDs for vaccination.

The pharmacy empowered team members to deliver some aspects of the minor ailments service (eMAS) within their competence. Team members collected relevant information from people, then checked with pharmacist. They did not dispense medicines until the pharmacist had approved the recommendation or counselled the person. 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 regular pharmacist who was not present during the inspection was trained and competent to undertake vaccinations. She had not yet done this in this pharmacy as she had only been here for a few months. She had delivered travel and flu vaccination in her previous role. The pharmacy had offered flu vaccination in previous years for occupational health and as a private service. The pharmacist usually delivered the smoking cessation service and team members knew there had been a recent success. All team members were trained and competent to measure blood pressure and undertake the diabetes risk assessment and testing. The pharmacy had recently introduced a charge for these two services and people were rewarded with a voucher to spend in the pharmacy over the following three months. The pharmacist did not charge people when she identified a need, or the GP practice had referred people to the pharmacy.

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). All team members undertaken 'my-learn' training but had not received practical training. The pharmacy had the equipment. 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 had recently undertaken an e-learning module on pharmacovigilance. 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. 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, an anaphylaxis kit and blood testing equipment calibrated as per guidance. Team members kept BS 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 stored paper records in the dispensary and cupboards in the consultation room 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.