General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 141 High Street, AUCHTERARDER, Perthshire, PH3 1AD

Pharmacy reference: 1111767

Type of pharmacy: Community

Date of inspection: 05/04/2022

Pharmacy context

The pharmacy is located on a busy high street in a village. And it provides a range of services, including the Medicines Care Review service, blood pressure checks, diabetes checks and smoking cessation. It uses Patient Group Directions to supply medicines for emergency hormonal contraception, skin infections and the flu vaccine. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it provides medicines to one medium sized care home. The inspection was carried out during the Covid-19 pandemic.

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 identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate, to show that its medicines are supplied safely and legally. Team members take appropriate action to ensure that vulnerable people are protected.

Inspector's evidence

The pharmacy had carried out workplace risk assessments in relation to Covid-19. And it adopted adequate measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members generally identified and rectified their own mistakes. The pharmacist explained that she would point out the mistake if the pharmacy was busy or the prescription was urgent. One of the accuracy checking technicians (ACT) was the 'Safer Care' champion for the pharmacy. She showed how near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And a 'look alike, sound alike' (LASA) stamp was used on prescriptions at the point of the dispensing labels being produced, to help team members select the correct medicine. Amitriptyline had been moved to a different drawer than amlodipine, as there had been several selection errors involving these medicines. Separating them had helped to minimise the number of near misses with these medicines. The outcomes from the reviews were discussed openly during the regular team meetings. And learning points were also shared with other pharmacies in the company. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The ACT said that there had not been any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. The pharmacy's head office was made aware of any errors.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. There were separate areas for dispensing and checking medicines. The pharmacists checking area was clear and she only checked one person's prescription at a time. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The pharmacist initialled prescriptions once they had been clinically checked. The ACTs knew which medicines they could check and that they could not carry out an accuracy check on an item if they had been involved in the dispensing process. The ACTs had been trained and signed off to check higher-risk medicines and controlled drugs (CDs).

Team members' roles and responsibilities were specified in the SOPs. The ACT said that the pharmacy would remain closed if the pharmacist had not turned up. If the pharmacist had not arrived after 15 minutes the Health Board and the pharmacy's head office would be notified. The ACT knew that she

should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription records were completed correctly. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This made it easier for the pharmacy to show why the medicine was supplied if there was a query. There were signed in-date patient group directions available for the relevant services offered. CD registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and people using the pharmacy could not see information on the computer screens. Bagged items waiting collection could not be viewed by people using the pharmacy. Team members had completed training about data protection.

The pharmacy's complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. One of the ACTs said that she was not aware of any recent complaints. And she would refer any to the pharmacist.

The pharmacist had completed training about protecting vulnerable people. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. One of the ACTs gave an example of action they had taken in response to a safeguarding concern. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they receive some ongoing training to support their learning needs and to maintain their knowledge and skills. Team members can raise any concerns or make suggestions and have regular meetings. The team discusses adverse incidents and uses these to learn and improve. Team members take professional decisions to help people take their medicines safely.

Inspector's evidence

There was one pharmacist (locum), one pharmacy manager (healthcare partner), two ACTs, one trained healthcare partner and one trainee healthcare partner working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. Team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The inspector discussed with the pharmacy manager about the reporting process in the event that a team member tested positive for the coronavirus.

The trainee healthcare partner appeared confident when speaking with people. She was aware of the restrictions on sales of products containing pseudoephedrine. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She used effective questioning techniques to establish whether the medicines were suitable for the person.

The pharmacy manager said that team members were provided with ongoing training on a regular basis. They were sometimes allowed time during the day to do it, but this was not always possible due to the workload. The manager explained that she was planning to implement a system where team members were allocated different tasks each day and training time would be factored into the timetable.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And she felt able to take professional decisions. She had completed the necessary training for the services offered, as well as associated training. And she had undertaken recent face-to-face training about the flu vaccination service. She explained that she regularly read pharmacy-related articles online and passed on relevant information to other team members. She said that she had completed some recent training about epilepsy pharmacology and nicotine replacement therapy products.

Team members felt comfortable about discussing any issues with the pharmacist or pharmacy manager or making any suggestions. The pharmacy manager explained that team members were due to have appraisals and performance reviews. But these had been delayed due to the pharmacy not having a manager recently. The pharmacy manager said that the pharmacy's area manager spoke with the pharmacy a few times each week to ask about any issues and discuss the pharmacy's workload. And that the area manager regularly visited the pharmacy. The pharmacy manager said that she felt supported in her new role. The team had regular reviews of any dispensing mistakes and discussed these openly during the regular team meetings.

Targets were set for some services including Pharmacy First. The pharmacy manager said that the services were provided for the benefit of the people using the pharmacy. And the team would not let the targets affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout, which presented a professional image. Pharmacy-only medicines were kept behind the counter or behind clear screens in the shop area. The screens displayed notices asking people to ‘ask for assistance’. There was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

A one-way system was marked on the floor in the shop area, and there were stickers on the floor reminding people to socially distance from each other. There were two chairs in the shop area, and both had arms to aid standing. The chairs were positioned close to the medicines counter which increased the risk of conversations at the counter being heard. The pharmacy manager said that the consultation room would be used if a person wanted to speak with a team member in a more private setting.

The consultation room was accessible to wheelchair users and it was located next to the medicines counter. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of health needs can access the pharmacy's services. The pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. And it dispenses medicines into multi-compartment compliance packs safely.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. There were steps from the main shop area up to the medicines counter and a lift was available next to the steps. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. And the pharmacy could produce large-print labels if needed.

The pharmacy supplied medicines to some people as part of the Medicines Care Review service. The barcode on the prescription was scanned at the time the medicines were handed out and the prescription was annotated with a date for six weeks' time. The prescription was then placed in the corresponding file. The prescriptions were kept in separate plastic folders to help team members distinguish them from other prescriptions. When the last supply had been made and the prescription was scanned, a request for another prescription was sent electronically to the person's GP.

The pharmacist explained the Pharmacy First service process. The trainee healthcare partner knew when to refer to the pharmacist and would discuss requests for medicines with a team member who was trained to enter the consultation onto the electronic system. Universal claim forms were generated and always checked by the pharmacist before items were supplied to people.

The pharmacist explained the unscheduled care system and occasions when she would supply a medicine, and when she would not. If the person's surgery was open, she would attempt to contact the person's GP and request a prescription in the first instance. She mainly used the service to change the form of a medicine to a liquid for a child who might not be able to take tablets or capsules.

The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted and the date the items were not to be handed out after was written on the sticker. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that CD and fridge items were checked with people when handed out. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy had the relevant patient

information leaflets and warning cards available. The pharmacist said that she would make a note on the patient's medication record if they were on a PPP.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months were clearly marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Prescriptions for alternate medicines were requested from prescribers where needed. Uncollected prescriptions were checked weekly. The ACT explained that people were sent a text message when their items were ready to be collected, and a reminder message a week later. Items remaining uncollected after four weeks were returned to dispensing stock where possible and prescriptions for uncollected CDs were returned to the prescriber.

The ACT said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The ACT said that people usually ordered prescriptions from their GP if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures for most items, to help minimise the spread of infection. But it had obtained people's signatures for CD deliveries where possible and these were recorded in a way so that other people's information was protected. This made it easier for the pharmacy to show that the medicines were safely delivered. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were used to measure marked measuring certain higher-risk liquids. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Triangle tablet counters were available and clean. And a separate counter was kept in a clear plastic bag with tweezers, and it was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for less than one year and the date it was first used was annotated on the machine. The ACT said that it would be replaced in line with the manufacturer's guidance. The weighing scales were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed. There was personal protective equipment available, including masks, gloves, hand sanitiser. Team members used these to help minimise the spread of infection.

Fridge temperatures were checked daily, with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. There was an occasion recently where the temperature had been out of range due to a brief power cut. The thermometer had been reset and rechecked, and the reason for the anomaly was recorded along with the temperatures.

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.