General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ladywell Pharmacy, 45 Fernbank, LIVINGSTON, West Lothian, EH54 6DT

Pharmacy reference: 1116887

Type of pharmacy: Community

Date of inspection: 08/06/2023

Pharmacy context

This is a community pharmacy within the neighbourhood of Ladywell in Livingston. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs for people who need help remembering to take their medicines at the right times. The pharmacy offers a medicines delivery service. It also provides substance misuse services and dispenses private prescriptions. And it supplies a range of over-the-counter medicines. The pharmacy team advises on minor ailments and medicines' use.

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. And pharmacy team members follow written procedures to help them work safely and effectively. The pharmacy keeps good records of the mistakes that happen during the dispensing process. Members of the team use the records to help learn from these mistakes. And they take action to avoid them being repeated. They keep the records they need to by law, and they keep people's private information safe.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). The SOPs covered tasks such as the prescription handling, responsible pharmacist (RP) regulations, and safeguarding. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. The superintendent (SI) pharmacist was in the process of reviewing SOPs and some newer team members had not signed to confirm they had read all of the SOPs. The pharmacy employed an Accuracy Checking Technician (ACT). Team members described the process for prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions. This enabled the ACT to complete the accuracy check. The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members described the process for the pharmacy closure when there was no responsible pharmacist available.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as 'near misses.' And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors and discussed these in a team meeting each month to learn from them. And they introduced strategies to minimise the chances of the same error happening again. Team members had identified that more errors occurred for medicines selected outwith the dispensing robot. So they implementing a second check on medicines that had been selected manually to reduce the chance of error. The pharmacy had a complaints procedure and welcomed feedback directly from people in the pharmacy as well as online via their website.

The pharmacy had current professional indemnity insurance. It displayed the correct responsible pharmacist notice and had an up-to-date responsible pharmacist record. Private prescription records appeared to be in order, including records about emergency supplies and veterinary prescriptions. It kept records for unlicensed medicines. The pharmacy kept electronic controlled drug (CD) records with running balances. A random balance check matched the balance recorded in the register. Stock balances were checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. Electronic patient medication records (PMR) were regularly backed up to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for secure, certified destruction by an external company. No person-identifiable information was visible to the public. The pharmacy had a documented procedure to help its team members raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member explained the process they would follow if they had concerns and would raise concerns to the

RP. They were aware of the Ask for ANI (action needed immediately) scheme to help people suffering domestic abuse access a safe place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to safely provide the pharmacy's services. They manage their workload well and support each other as they work. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service. And the pharmacy has adequate procedures in place to help its team manage the workload in the event of unplanned staff absence.

Inspector's evidence

The pharmacy employed one full-time pharmacist manager, one full-time accuracy checking technician (ACT), two full-time pharmacy technicians and three full-time dispensers. There was also a part-time trainee medicines counter assistant, a pharmacy student on Saturdays and a full-time delivery driver. The pharmacy also had a trainee pharmacist undertaking their foundation training year, a part-time trainee technician undertaking a joint placement with the NHS and the pharmacy received support from a second pharmacist two to three days most weeks. Typically, there were eight team members working at most times.

Team members were seen to be managing the workload. Those spoken to during the inspection were experienced in their role. They demonstrated a good rapport with people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. The pharmacy reviewed staffing levels regularly. It used rotas to manage staff levels depending on workload. Part-time team members had some scope to work flexibly providing contingency for absence. The pharmacy planned learning time during the working week for all team members to undertake regular training and development. It provided team members undertaking accredited courses with additional time to complete coursework. A trainee team member was observed being supervised in their role and described the training plan that they were working through. Team members had annual appraisals with the pharmacy manager to identify their learning needs. Members of the team were observed to work on their own initiative, for example contacting the doctor and carer of a person who was forgetting to take their medicines. They asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when unsure. They demonstrated an awareness of repeat requests for medicines intended for short term use. And early requests for prescriptions for medicines prone to misuse. They dealt appropriately with such requests and kept records of these.

Pharmacy team members understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. They felt able to make suggestions and raise concerns to the manager. The pharmacy team discussed incidents and how to reduce risks and had monthly team meetings. The pharmacy had a whistleblowing policy that team members were aware of. There were no set targets for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. They are clean, secure, and well maintained. And the pharmacy has a suitable room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises were average-sized, incorporating a retail area, dispensary with large dispensing robot and a small 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. Its overall appearance was professional. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room which was clean and tidy with a desk, chairs, sink and laptop computer, and the door closed which provided privacy. The pharmacy also had a separate area for specialist services such as substance misuse supervision. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. And it manages its services well to help people look after their health. The pharmacy correctly sources its medicines, and it completes regular checks of them to make sure they are in date and suitable to supply. And the pharmacy team provides appropriate advice to people about their medicines.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. The pharmacy advertised its opening hours beside the main window, and this could be seen when the pharmacy was closed. It could provide large print labels for people with impaired vision. 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.

Pharmacy team members followed a logical and methodical workflow for dispensing with a dispensing robot used. The robot had five workstations and outlet chutes. They used coloured baskets to differentiate between different prescription types and to separate people's medicines and prescriptions. And they attached coloured labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. A team member prepared the day's deliveries prior to the delivery driver arriving. The driver used an electronic device to record deliveries, and this could be accessed by team members in the dispensary. This ensured that team members were aware of the day's scheduled deliveries. This was useful if people called the pharmacy asking about their expected delivery.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these when people notified them they were required. Team members only prepared the medicines that were requested by people in order to avoid waste. They maintained records of when people collected their medication. This meant the pharmacist could then identify any potential issues with people not taking their medication as they should. The pharmacy notified the GP practice for a further prescription when all episodes of the prescription were collected. And they added notes of any care issues identified. This helped make sure people's medicines were reviewed by their GP appropriately. The pharmacist carried out pharmaceutical care needs' assessments. They sometimes identified pharmaceutical care issues when discussing people's medicines with them. The pharmacist explained they had contacted the GP practice after completing a review of a patient who was no longer suitable for this type of prescription. And arranged for an appropriate replacement to be issued.

The pharmacy dispensed medicines in multi-compartment compliance packs to a high volume of people who needed extra support with their medicines. Pharmacy team members managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person. These master sheets documented the person's current medicines and administration time and notes of previous changes to medication. Compliance packs were labelled so people had written instructions about how to take their medicines. These labels included descriptions of what the medicines looked like, so they could be identified in the pack. And team members provided people with

patient information leaflets about their medicines each month. Shelving to store the packs was kept neat and tidy. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving higher-risk medicines including methotrexate, lithium, and warfarin. People were supplied with written information and record books if required. Team members had knowledge of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to apply dispensing labels to valproate packs in a way that prevented any written warnings being covered up. And they always dispensed valproate in the original pack. The pharmacy had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, emergency hormonal contraception (EHC), and impetigo treatment. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves and in the large dispensing robot. Stock control rules for the robot were attached to the wall beside the control screen. Boxes containing split packs, where tablets had been removed to dispense a prescription, were given a six-month expiry date, which was less that the manufacturers expiry. Date checking was undertaken regularly, and expired items removed from the robot. Team members regularly checked expiry dates of medicines stored on shelves. A random sample was inspected, and all were found to be in date. Team members used space well to segregate stock, dispensed items, and obsolete items. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. The pharmacy had disposal bins for expired and patient-returned stock.

The pharmacy received electronic notification of Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts. The electronic system kept records about what had been done and which team member was responsible. Team members explained they would contact 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 to provide safe services. And it uses its facilities to suitably protect people’s private information.

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 access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines. Team members kept clean crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in the dispensary, inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by 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.