General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lyoncross Pharmacy, 54 Lyoncross Road, Pollok, GLASGOW, G53 5UW

Pharmacy reference: 1123845

Type of pharmacy: Community

Date of inspection: 30/07/2019

Pharmacy context

The pharmacy is on a parade of shops, in a residential area of Pollok. It dispenses NHS prescriptions and provides a range of extra services. The pharmacy collects prescriptions from the local surgeries. And it supplies medicines in multi-compartmental compliance packs when people need extra help with their medicines. Consultation facilities are available, and people can be seen in private.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

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	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 team members complete training and work to professional standards. They provide safe services and look after people's welfare. But, the team members would benefit from having access to a safeguarding policy. And this would ensure they understand their role in protecting vulnerable people. The pharmacy keeps records of mistakes when they happen. And team members discuss the need for new safety measures. And there is ongoing service improvement. The pharmacy keeps the records it needs to by law. And it keeps people's confidential information safe. The pharmacy team member's know to follow the company's complaints handling procedure. This means they listen to people and put things right when they can.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy processes and procedures. The team members signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The pharmacy had displayed the responsible pharmacist notice. And it showed the name and registration number of the pharmacist in charge. The pharmacist kept sample signatures of all team members. And ensured they could be identified when the pharmacist was off-duty. The pharmacy team members signed most of the dispensing labels to show they had completed the dispensing task. But multi-compartmental compliance packs had not always been signed by the dispensers. The pharmacist checked prescriptions. And gave feedback to dispensers who failed to identify their own errors. The pharmacist had recorded around 4 near-misses each month over the last quarter. But had not always recorded how the errors could have happened. The pharmacy team discussed the errors. And introduced new ways of working to manage significant risks. For example, the different pack sizes of co-dydramol packs had been separated to manage the risk of quantity errors. The pharmacy had been re-arranging all its stock. And putting it into alphabetical order. This aimed to make it easier for new team members to find items. And to reduce the time people waited on their prescriptions. The pharmacist acted on patient safety bulletins. And had reviewed their multi-compartmental compliance pack dispensing processes. And had agreed to introduce a new safety measure. This involved checking the backing sheet against the prescription collection and delivery records to ensure the correct pack was supplied to the correct person.

The pharmacist managed the incident reporting process. And a new incident report template had been recently introduced at the suggestion of one of the dispensers. The pharmacy team knew when incidents happened and what the cause had been. For example, they knew about a mix-up when the wrong strength of a controlled drug had been supplied. The pharmacist had reflected on the incident. And had decided to place the item in a separate basket following the final accuracy check. The pharmacist carried out a second accuracy check at the time of supply when the item was bagged and issued. The incident report had been shared with the CDAO at the Health Board. A complaints policy ensured that staff handled complaints in a consistent manner. But, the pharmacy did not display complaints information. And did not inform people how they could complain if they wanted to. The pharmacy displayed a patient questionnaire. And encouraged people to provide feedback about how they thought services could be improved upon. People had been completing the forms. But had not

suggested areas for improvement. And most people had stated that they were satisfied with the service.

The pharmacy maintained the legal pharmacy records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy team kept the controlled drug registers up to date. And had last checked and verified the balance of controlled drugs in May 2019. The pharmacy dispensed a significant quantity of methadone doses. And checked and verified the balance once a week incorporating overages when needed. The pharmacy team recorded controlled drugs that people returned for destruction. And the pharmacist and a team member recorded their name and signature against each destruction. The pharmacy had last received unwanted controlled drugs for destruction in January 2019. The pharmacy provided a delivery service to housebound and vulnerable people. And made sure that people signed for controlled drugs to confirm receipt. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date and met requirements with details of what had been supplied and who had received it. The pharmacists used patient group directions to improve access to medicines and advice. But current copies were not available for inspection. Public liability and professional indemnity insurance were in place and valid until February 2020.

The pharmacist had carried out a review to ensure that confidential information was safeguarded. And had moved weekly prescriptions awaiting collection. This was due to the risk of them being seen by people using the consultation room. The pharmacy team had been trained to safeguard personal information. The team members used a shredder to securely dispose of confidential waste. And archived spent records for the standard retention period. The pharmacy displayed a notice on the medicines counter asking people to keep a safe distance away from the dispensary to safeguard information.

The pharmacist had registered with the protecting vulnerable groups scheme (PVG). And this was used to help protect children and vulnerable adults. The pharmacy team members had not been formally trained to identify the signs and symptoms of abuse and neglect. But they knew who their vulnerable groups were. And knew to speak to the pharmacist when they had concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And ensures it has the right number of pharmacy team members with the right skills throughout the week. The pharmacy team members are supported to improve their performance. And discuss their learning needs with the pharmacist to keep up to date. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides some access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they are encouraged to make improvements to keep services safe and effective.

Inspector's evidence

The pharmacy had not experienced any significant growth over the past year. And the work-load had remained mostly stable. The pharmacist did not use targets to drive the business. And expected the pharmacy team to provide a good service to develop customer loyalty. And, the new dispenser had managed to increase the number of people using the smoking cessation service. The pharmacy had replaced team members who had left. And a new full-time dispenser had taken up post in January 2019. Another part-time dispenser had started in July 2019. The pharmacy retained qualifications on-site. And the capacity and capability of the pharmacy team continued to meet the demands of the service. The following team members were in post; one full-time pharmacist, one full-time dispenser and two part-time dispensers. The pharmacist managed annual leave requests. And cover was provided from within the team.

The pharmacy did not use a formal appraisal to identify areas for development. But, it discussed training on an ongoing basis. For example, the new full-time dispenser had been encouraged to enrol on the NVQ pharmacy services level 3 course. And the pharmacist had applied to the training provider and was waiting on a response. A new part-time dispenser had not worked in a pharmacy for around eight years. And an individual near-miss form was being kept to identify knowledge and skills gaps. For example, the pharmacist had provided coaching when she had not been selecting all the required items to be dispensed into multi-compartmental compliance packs. And had discussed the need for improved accuracy in dispensing before passing to another dispenser or the pharmacist. The team member had been involved in re-arranging pharmacy stock so that she became familiar with look-alike and sound-alike medication.

The pharmacist updated the pharmacy team whenever there were service changes. For example, when pregabalin and gabapentin were re-classified as Schedule 3 controlled drugs. And this ensured that team members asked people to sign for their prescriptions. The pharmacist issued training materials from pharmacy magazines. But did not assess whether the pharmacy team had learnt from them.

The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. And a new dispenser had been encouraged to apply her experience of working in different pharmacies. For example, she had suggested dispensing methadone doses once a week instead of each day. And this had saved time in terms of dispensing and carrying out the associated governance tasks.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean. And provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy was modern and presented a professional image to the public. A large well-kept waiting area provided seating. And a range of patient information leaflets were available for self-selection. Two consultation rooms were available. But only one was in use. And an integrated hatch was used to provide supervised doses. The pharmacy had ample allocated benches for the different dispensing tasks. And a large rear area was used for dispensing methadone doses and storing multi-compartmental compliance packs. The pharmacist supervised the medicines counter from the checking bench. And made interventions when necessary. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times in the window. And provides access to healthcare information leaflets to let people know what services and support are available to them. The pharmacy has working instructions in place for its services. And these support the pharmacy team to work in a safe and effective way. The pharmacy dispenses multi-compartmental compliance packs. But, does not always supply extra information to these people to support them to take their medicines. The pharmacy sources, stores and manages its medicines appropriately. And works with prescribers to make sure people taking some high-risk medicines get support to take these medicines safely.

Inspector's evidence

The pharmacy had a stepped entrance. And the pharmacy team monitored the entrance with CCTV so they could provide support to people with mobility difficulties. The pharmacy displayed its opening hours in the window. And displayed healthcare information leaflets in the waiting area. The dispensary benches were organised. And the pharmacy team used dispensing baskets to keep prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for people who needed extra support. And the pharmacy team had read and signed a valid SOP. The pharmacy team used trackers to manage the work. And this helped to manage the risk of people going without their medication. The team members isolated packs when they were notified about prescription changes. And kept a record of changes including the name of the person authorising the change in the person's records. The pharmacy kept a list of people that had been admitted to hospital. And this was updated on a regular basis. The pharmacy did not always provide descriptions of medicines with the pack. And did not always supply patient information leaflets. The team members dispensed methadone doses once a week to manage the work-load. And they obtained an accuracy check at the time of dispensing and at the time of supply. The pharmacy provided a delivery service to housebound and vulnerable people. And made sure that people signed for controlled drugs to confirm receipt.

The team members kept the pharmacy shelves neat and tidy. And purchased medicines and medical devices from recognised suppliers. They kept the pharmacy shelves neat and tidy. And kept controlled drugs in a large well-organised cabinet. The pharmacy team carried out regular stock management activities. And highlighted short-dated stock and part-packs during regular expiry date checks. A new dispenser had suggested keeping a note of short-dated stock, so it was removed in time. The pharmacy had removed expired stock from shelves. And this was segregated awaiting disposal. The team members monitored and recorded the fridge temperatures. And demonstrated that the temperature had remained between two and eight degrees Celsius. The pharmacy accepted returned medicines from the public. And disposed of them in yellow containers that the health board collected.

The pharmacy team acted on drug alerts and recalls. And the dispenser knew to check the GOV.UK website when the pharmacist was off-duty. The pharmacist retained drug alerts in a folder. But did not

document what the outcome had been. The pharmacist identified people who had been issued with valproate prescriptions. And ensured the GP had considered the need for medication changes or the pregnancy protection programme. The team members knew about the valproate pregnancy protection programme. But did not know about the requirement to supply safety cards and leaflets. And the pharmacy needed to ensure that supplies were always available. The pharmacy had implemented the Falsified Medicines Directive (FMD). And was scanning what medicines it could to comply with requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it keeps it clean and well-maintained.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). It uses crown-stamped measuring equipment. And the measures for methadone only use were highlighted and separated. The pharmacy displayed a notice to remind the pharmacy team to wear protective gloves when dispensing high-risk medication, such as methotrexate and finasteride. And the team members used separate counting triangle to avoid contamination. The pharmacy used a methadone pump. And a record was used to document the weekly calibrations. A new pump had been ordered. And was available as a back-up. The pharmacy kept cleaning materials for hard surface and equipment cleaning. And the pharmacy sink was clean and suitable for dispensing purposes. The pharmacy stored prescriptions for collection out of view of the waiting area. And arranged computer screens so they were only visible by pharmacy team members. The pharmacy used portable phones. And the pharmacy team took calls in private when necessary.

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.