General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 37 Henderson Street, Bridge of Allan, Stirling, Stirlingshire, FK9 4HN

Pharmacy reference: 9010303

Type of pharmacy: Community

Date of inspection: 19/01/2023

Pharmacy context

This is a community pharmacy in Bridge of Allan. It dispenses NHS and private prescriptions and provides a substance misuse service. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

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 uses documented 'standard operating procedures' (SOPs) for its services. Team members follow the SOPs to manage risks and to keep services safe. But they are inconsistent with record keeping for auditing and monitoring activities. This means the pharmacy may miss opportunities to learn and improve. Pharmacy team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law.

Inspector's evidence

The pharmacy had control measures to manage the risks and help prevent the spread of infections. This included a plastic screen at the medicines counter and hand sanitizer at the medicines counter for visitors and team members to use. The pharmacy used 'standard operating procedures' (SOPs) which defined the pharmacy's working practices. The company issued new SOPs via an online operating system. And the system notified pharmacy team members when new SOPs were released. Team members indicated when they had read the SOPs, and the system updated individuals learning records to evidence they had read them. The company provided teams with reports to show compliance with SOP requirements. This meant that managers could identify gaps and act to ensure that team members were up to date. A review of some SOPs showed the 'responsible pharmacist' and 'controlled drug' procedures were up to date. The company had recently issued a new SOP that defined the process to follow for receiving prescriptions. And team members had indicated they had read and understood it. The pharmacy had policies in place for services. This included diabetes testing, blood pressure checks and cholesterol monitoring.

Dispensers signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist was able to help individuals learn from their dispensing mistakes. The company had introduced bar-code scanning technology that helped to identify selection errors. But the new system had been unable to recognise more than 25% of the items the pharmacy dispensed. Team members knew to reflect and to record the reason why a near miss may have happened. But records showed they had last documented near misses in November 2022. This meant they may be missing opportunities to learn and improve.

The pharmacy carried out regular audits to identify dispensing risks. Team members followed a four weekly audit schedule that included environmental factors, staff training and culminated in a team briefing on week four. A recent documented team briefing showed that team members had identified 'wrong strength' as the most common cause of near miss errors. The reason provided was due to significant sickness in December 2022 and overfilled drawers. Team members had identified improvement actions as a result. This included sending excess stock back to a central location in the company to manage the risk of selection errors. They also agreed to manage their stress levels and not to rush tasks. Team members had been proactive to manage other risks with 'look alike sound alike' (LASA) items such as amlodipine and amitriptyline tablets. And they had separated them and added a shelf edge caution label. Team members knew to record dispensing incidents on an electronic template which they sent to the superintendent's office. The template included a section to record information about the root cause and any mitigations to improve safety arrangements. The pharmacy provided

information about its complaints process in a company leaflet. But the leaflet was behind the medicines counter and not available for self-selection. A regional manager visited the pharmacy on a regular basis to audit compliance with the company's governance arrangements. They had audited the pharmacy in the last six months and the 'responsible pharmacist' (RP) confirmed they were unaware of any outstanding actions.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place which were valid until 30 June 2023. The pharmacist displayed an RP notice which was visible from the waiting area. And they kept an electronic RP to show when their duties began and ended. Team members maintained 'controlled drug'(CD) registers and kept them up to date. Records showed they carried out balance checks every week for most items. People returned CDs they no longer needed for safe disposal. And team members used a CD destruction register to document items. The pharmacist signed the register to confirm items had been safely disposed of. Team members filed prescriptions so they could easily retrieve them if needed. The pharmacy kept records of private prescription supplies. And records complied with legal requirements. They were clear and legible and the associated paper prescriptions were kept in a folder in date order. Team members kept certificates of conformity for unlicensed medicines, and these complied with Medicines & Healthcare Regulatory Agency (MHRA) requirements.

The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. A policy was available for them to refer to. They used a designated container to dispose of confidential waste. And an approved provider collected the waste for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And it provided a policy for them to refer to. A list of contact details for local agencies was prominently displayed on the dispensary wall. Team members knew to speak to the pharmacist whenever they had cause for concern. And the dispenser provided an example when they had contacted the surgery to inform them of difficulties delivering someone's medication to them and this was resolved. A chaperone notice on the consultation room door advised people they could request to be accompanied whilst in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they work together to suitably manage the workload. The company supports team members to develop in their roles. And they continue to learn to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy's prescription workload had fallen over the past year. And the company had subsequently reduced the number of hours worked by the pharmacy team. A regular 'responsible pharmacist' (RP) had been in post since September 2022. And the pharmacy team was a combination of new and long serving experienced staff. A regular locum pharmacist provided cover for the RPs days off. And a regional manager liaised with the pharmacy to arrange cover. This was mostly to send team members to other branches to cover shortages. At the time of the inspection the full-time non-pharmacist manager and another part-time dispenser were working in other branches to provide extra help and support. This had not impacted on the pharmacy and the remaining team members were managing their workload well. The pharmacy team comprised of one full-time pharmacist, one full-time dispenser (non-pharmacist manager), four part-time dispensers, one part-time medicines counter assistant and two delivery drivers.

The pharmacist supported team members to learn and develop. They provided protected learning time in the workplace when possible. Learning included reading the relevant 'standard operating procedures' (SOPs) and completing health and safety training. The company delivered mandatory training via its online operating system. And team members completed regular pharmacovigilance training which included data protection training. Team members attended off-site training that the health board provided. The non-pharmacist manager had attended an evening event in November 2022 and had shared the learnings with the rest of the team on her return. A pharmacy technician from the health board had delivered on-site training in the pharmacy. And a few team members had attended the training and had learned to operate a new system to improve communications between the pharmacy and the health board for various services. The system also included a facility to report missed doses of some medications so that alternative arrangements could be made in a timely manner.

Team members kept up to date with the reading of new policies and procedures, and they had recently signed to show they had read a new medicines sales protocol that the company had issued. The RP had reviewed and updated the new protocol to reflect local practices. And they had added extra medicines to a list so that team members knew when to refer to the pharmacist. This included Ella One and chloramphenicol eye drops and ointment.

Each month, team members discussed audit and monitoring findings. This included discussions about the risks that had been identified and safety improvements. The RP encouraged team members to suggest improvements in the areas that they worked. For example, they had changed the way they filed repeat prescriptions to be more compatible with a new operating system that the company had implemented. They also changed the day they sent prescription information to an off-site dispensing hub for multi-compartment compliance packs. This had helped the team to better manage their

workload. Team members were aware of whistleblowing procedures. And they felt empowered and able to speak up if they had a concern.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises support the safe delivery of services. But team members do not always use the pharmacy's storage facilities to safely keep some of the items it used. The pharmacy suitably manages the space for the storage of its medicines. The pharmacy has appropriate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was in large, modern purpose-built premises. A sound-proofed consultation room with hot and cold running water was available for use. And it provided a clinical environment for the administration of flu vaccinations and to carry out various checks such as blood pressure monitoring and cholesterol testing. The consultation room provided a confidential environment. And people could speak freely with the pharmacist and the other team members during private consultations. The pharmacist disposed of clinical waste in a designated sharps container. And a locked cupboard was available to secure the container when not in use.

A sink in the dispensary was available for hand washing and the preparation of medicines. And a dedicated area for comfort breaks was available for team members to use. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services.

Team members had organised the benches in the dispensary for different tasks. And a separate rear area provided extra space for the delivery driver to sort prescriptions and the documentation used for deliveries. The pharmacist supervised the medicines counter from the dispensary and could intervene and provide advice when necessary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team carries out checks to make sure medicines are in good condition and suitable to supply. And it removes medicines that are no longer fit for purpose.

Inspector's evidence

The pharmacy had a step-free entrance and an automatic door to provide unrestricted access for people with mobility difficulties. It advertised services and opening hours at the front of the pharmacy. And had a range of health information leaflets on display. But the leaflets were either behind the medicines counter or in the consultation room and unavailable for self-selection. The pharmacy was offering appointments for both NHS and private flu vaccinations. And team members directed people to an online booking system for appointments. They could close the booking system when appropriate, such as when they were short-staffed. And this helped the pharmacy team manage their workload and maintain service continuity.

Team members kept stock neat and tidy on a series of shelves and drawers. And they used secure cabinets to store some items. The pharmacy purchased medicines and medical devices from recognised suppliers. And a date checking matrix was used to keep track of when checks were next due. Sampling showed stock items were in date. A large glass-fronted fridge kept medicines at the manufacturers recommended temperature. And team members monitored and recorded the temperatures every day. This provided assurance that the fridges were operating within the accepted range. Team members checked the company's online system for drug alerts. And they updated the system once they had carried out the necessary checks. The pharmacy used medical waste bins and CD denaturing kits to dispose of items. And this supported the pharmacy team to manage pharmaceutical waste. The pharmacy had trained team members about valproate medication and the Pregnancy Prevention Programme for people at risk. And they knew to supply patient information leaflets and to provide cards with every supply and extra supplies were kept.

Team members had organised the dispensary to keep their working environment safe. The pharmacist positioned themselves so they could supervise the medicines counter. And team members worked at various workstations depending on the tasks they were carrying out. Dispensing baskets kept medicines and prescriptions safely contained during dispensing. And this managed the risk of items becoming mixed-up and the risk of dispensing mistakes.

The pharmacy helped people to manage their prescriptions and re-ordered supplies on their behalf. They kept the different types of prescriptions well-segregated including serial prescriptions for a significant number of people that had registered with the 'medicines: care and review' service (MCR). Team members had a system in place for dispensing serial prescriptions. And they had made recent changes to manage the number of prescription changes and the need to dismantle them. Team members has stopped dispensing items in advance and dispensed them on demand. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could check compliance. Team members dispensed multi-

compartment compliance packs to help people with their medicines. They sent some packs to an off-site hub for dispensing. And the pharmacist carried out clinical and accuracy checks before they were sent. Team members reconciled prescriptions with the packs on their return and added any items the hub had not supplied such as alendronic acid that was not suitable to be removed from its blister packaging. An online system helped team members with the re-ordering of new prescriptions for dispensing the packs. And they used supplementary records to check the new prescriptions for accuracy. Sheets attached to the packs listed the medications inside and provided all the relevant information and met the necessary labelling regulations. And team members kept records of prescription changes which they retained alongside people's medication records. Patient information leaflets were supplied with the first pack of the four-week cycle to help people with their medicines. Team members had a system for dispensing instalments of some medicines. And the pharmacist carried out a clinical check and an accuracy check for weekly dispensing. They carried out another accuracy check at the time of supply.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses its facilities to suitably protect people's private information. It has the equipment it needs to provide safe services. But it does not always have robust processes in place to show that equipment is safe and effective.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse treatments. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy provided blood pressure checks. Team members had recently renewed the monitor, but they could not show when this had been. So, they would not be able to tell when a new machine was needed. The pharmacy provided blood glucose checks. But team members could not adequately describe how they carried out calibrations to confirm readings were accurate. The pharmacy provided cholesterol checks. But team members could not adequately describe how they carried out calibrations to confirm readings were accurate.

The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

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.