General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 1600 Great Western Road, Glasgow, G13 1HF

Pharmacy reference: 9011194

Type of pharmacy: Community

Date of inspection: 12/02/2020

Pharmacy context

This is a community pharmacy located close to Anniesland cross. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It offers a repeat prescription collection service and a medicines' delivery service. And it provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers blood pressure and diabetes testing and a smoking cessation service. The pharmacy moved premises on 17 July 2019. And this was its first inspection.

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	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 work to professional standards. They understand their role in protecting vulnerable people. And they complete regular training to ensure they are up-to-date with safeguarding requirements. People using the pharmacy can raise concerns. And team members know to follow the company's complaints handling procedure. This means they listen to people and put things right when they can. Pharmacy team members record and discuss mistakes that happen whilst dispensing. And they use this information to learn and reduce the risk of further errors. They do not always collect detailed information about the causes of mistakes to help inform the changes they make. The pharmacy keeps the records it needs to by law. And it provides training for the team on how to keep confidential information. It has controls in place to keep people's private information secure.

Inspector's evidence

The pharmacy used working instructions to define the pharmacy processes and procedures. The team members had signed to confirm they followed the procedures. And to show they understood their roles and responsibilities. The pharmacy team members signed dispensing labels to show they had completed a dispensing task. And the pharmacist checked prescriptions and gave feedback to dispensers who failed to identify their own errors. The pharmacist and the team members recorded the errors. And the pharmacist sometimes recorded what the aggravating factors might have been. For example, when the team members had not checked the contents to confirm they had dispensed the correct quantity. And they had not marked the pack to indicate it was a part-pack. The team members were able to provide a few examples of changes to manage dispensing risks, such as separating olanzapine strengths to manage the risk of selection errors. And they had started using caution labels to highlight look-alike and sound-alike medication (LASA). For example, to highlight amlodipine/amitriptyline tablets. The team members had been carrying out regular weekly audits up until the end of 2019 to identify service risks. And they were able to provide assurance that the environment was safe and team members were up-to-date with training. The pharmacist kept the team up-to-date with safety risks. And they discussed their concerns and agreed remedial action to manage the risks. For example, in December 2019, the pharmacist had briefed the team about the difference between 'immediate release and prolonged release 'venlafaxine. And the pharmacist had attached a caution sticker to the storage drawers. The pharmacist managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, they knew about a recent incident which involved two team members from another branch when they had been providing cover. The pharmacist had carried out an investigation. And they had separated the different strengths of temazepam to manage the risk of a similar incident.

The pharmacy used a complaints policy to ensure that team members handled complaints in a consistent manner. And the company provided its branches with leaflets to inform people about its complaints process. But the pharmacy had run out of the leaflets and the team members said they would to re-order them. The pharmacy invited people to provide feedback about the services they received. And this had been positive with no suggestions for improvement.

The pharmacy maintained the records it needed to by law. And the pharmacist in charge kept the responsible pharmacist record up to date. The pharmacy had public liability and professional indemnity

insurance in place. And it was valid and up to date. The pharmacy team members kept the controlled drug registers up to date. And they carried out balance checks once a week. 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. A sample of private prescriptions were up to date and met legal requirements. And specials records were kept up to date with details of who had received each supply. The pharmacists used patient group directions (PGDs) to improve access to medicines and advice. And a sample showed that the NHS Greater Glasgow & Clyde Seasonal Influenza vaccination PGD was valid until August 2020.

The pharmacy did not display a notice to inform people about its data protection arrangements. And it did not inform people about how it kept their personal information safe. The company regularly trained the team members to comply with its data protection arrangements. And they knew how to safely process and protect personal information. The team members used designated bags to dispose of confidential waste. And these were regularly collected for off-site shredding. The team members archived spent records for the standard retention period.

The pharmacy displayed a chaperone notice beside both of its consultation rooms. And it used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The pharmacy team had been trained to follow the company's safeguarding policy. And this ensured the pharmacy team knew how to handle concerns. The company regularly trained the pharmacy team about vulnerable groups. And they knew to refer concerns to the pharmacist when they recognised the signs and symptoms of abuse and neglect.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy monitors its staffing levels. And it ensures it has the right number of suitably skilled pharmacy team members throughout the week. The pharmacy team members reflect on their performance. And they identify and discuss their learning needs at regular review meetings to keep up to date in their roles. The pharmacy encourages and supports the pharmacy team to learn and develop. And the pharmacy team members support each other in their day-to-day work. They can speak up at regular meetings. And make suggestions for improvement to keep services safe and effective.

Inspector's evidence

The pharmacy workload had increased by around 2000 items per month since its relocation in July 2019. And the number of team members had been increased by one and a half full-time equivalent trainee dispensers. The pharmacy had replaced team members when they left. And a new full-time trainee dispenser had been appointed around 10 months ago. This was a new team. But the pharmacy technician had worked at the branch for around 13 years. And was experienced and knowledgeable in their role. The pharmacy kept training qualifications on-site. And the following team members were in post; one full-time pharmacist, one full-time pharmacy technician, two full-time trainee dispensers, one part-time trainee dispenser, three pharmacy students working Saturdays and one delivery driver. The pharmacist continued to monitor the pharmacy's growth. And they discussed the current capacity and capability with the area manager to ensure it continued to meet the needs of the service. The pharmacy managed annual leave requests. And it maintained minimum levels by authorising only one team member to be off at the same time. The team members submitted annual leave requests in advance to help arrange cover. And the three students worked over the summer months to provide cover when most of the team members took their holidays.

The pharmacy manager carried out regular performance reviews to help the team members to improve and develop in their roles. For example, the pharmacy technician had recently enrolled onto the accuracy technician checking course. The pharmacy provided time to complete mandatory training. But the trainees that were undergoing formal training courses were expected to learn in their own time. And this was due to work-load demands and time constraints.

The company provided structured training. And this ensured the team members stayed up-to-date in their roles. For example, they had recently completed training about valproate, Aronix, the falsified medicines directorate and safeguarding. The company tested the team members to confirm that the learning had been effective. And they had to complete the module a second time if they failed to achieve the pass-mark. The company authorised the team members to attend Health Board training at off-site locations. For example, the pharmacist, pharmacy technician and one of the trainee dispensers were due to attend training about naloxone.

The company used targets to grow the services it provided. And the team members were currently identifying people that were suitable to be registered with the 'chronic medication service' (CMS). The team members did not feel undue pressure to meet the targets. And knew only to speak to people about services that would benefit them. The pharmacy team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had changed the way the multi-compartment compliance packs were stored. And a separate section of shelves were used to keep

packs for collection, packs for delivery and packs in quarantine due to prescription changes or people in hospital.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises is clean and hygienic. It has consultations rooms that are professional in appearance. And they are an appropriate space for people to sit down and have a private conversation with pharmacy team members.

Inspector's evidence

The pharmacy had relocated into a larger premises a short distance away. And it was providing services from a modern purpose-built facility. A large well-kept waiting area presented a professional image to the public. And it provided seating and some patient information leaflets for self-selection. The large dispensary was split with a separate area used to assemble and store the large number of multi-compartment compliance packs the pharmacy dispensed. The main dispensary had good bench space and storage areas. And this helped the team members to work in safe and effective way. The pharmacist supervised the medicines counter from the checking bench. And they could make interventions when necessary. The pharmacy had effective lighting. And the ambient temperature provided a comfortable environment from which to provide services. The pharmacy had two consultation rooms. And the team members used one for supervised services and flu vaccinations. And the other for general consultations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays its opening times and healthcare information at the front of the pharmacy. And it lets people know what services 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 sources, stores and manages its medicines appropriately. And the pharmacist keeps the pharmacy team up-to-date about high-risk medicines. This means that team members know when to provide people taking these medicines with extra information.

Inspector's evidence

The pharmacy had step free access. And a pressure operated pad was available for those that needed extra support. This provided unrestricted access for people with mobility difficulties. The pharmacy had installed a bell. And people could activate the bell to call on the team members to provide assistance. The pharmacy displayed some leaflets in the waiting area. And it displayed its opening hours in the window.

The pharmacist attached stickers to prescription bags. And the team members knew to alert the pharmacist when they needed to speak to people about their medication. Such as ensuring that people taking warfarin tablets knew to have their bloods tested. The pharmacist had trained the pharmacy team to speak to people about the chronic medication service (CMS). The CMS service provided people with extra support to help them take their medicines as prescribed. The surgery had only recently started issuing CMS prescriptions. And the team members knew to keep track so that they knew when the next supply was due. And to highlight when people arrived too early or late for their medication. This ensured someone spoke to them to find out if they were having difficulties.

The pharmacy team members used dispensing baskets. And they always kept prescriptions and medicines contained throughout the dispensing process. The pharmacy dispensed multi-compartment compliance packs for around 230 people. And the team members had read and signed the company's working instructions to confirm that dispensing was safe and effective. The pharmacist supervised multi-compartment compliance pack dispensing. And they re-ordered the prescriptions before new supplies were due. The pharmacist carried out a clinical check and processed the prescriptions. And they passed the backing sheets and prescriptions to the team members to collect the stock for dispensing. The team members passed the baskets back to the pharmacist. And they carried out an accuracy check before the team members filled the packs. The team members knew to alert the pharmacist to prescription changes. And they quarantined the packs until the pharmacist completed the necessary checks and changes. The team members supplied patient information leaflets. And they provided descriptions of medicines. The team members obtained signatures to confirm which pack had been collected. And this helped them to monitor supplies and to identify potential compliance issues which they referred to the pharmacist. The pharmacy provided a delivery service to housebound and vulnerable people. And the delivery driver obtained signatures to confirm that people had received their medication.

The team members dispensed methadone doses on the morning they were due. And they obtained an accuracy check before locking them in the controlled drug cabinet. The team members retrieved the prescriptions and selected the bottle from the cabinet when people arrived for their doses. And they

obtained an accuracy check at the time they made a supply.

The pharmacy purchased medicines and medical devices from recognised suppliers. The pharmacy kept most of its stock in a series of drawers. And they kept the most commonly used products on shelves above the dispensing benches. The team members carried out regular stock management activities. And they highlighted short dated stock and split-packs during regular checks. The team members monitored and recorded the fridge temperatures. And they demonstrated that the temperature had remained between two and eight degrees Celsius. The pharmacy used clear bags instead of paper prescription bags for controlled drugs and fridge items. And this allowed the pharmacist to easily carry out additional checks at the time of supply. The team members kept controlled drugs in three separate cabinets. And this managed the risk of selection errors, for example, they kept multi-compartment compliance packs in a separate cabinet.

The team members acted on drug alerts and recalls. And they recorded the date they checked for affected stock and the outcome. For example, in January 2020 they had acted on an alert concerning Zapain. And on checking the drawers they had no affected stock.

The company had trained the team members about the valproate pregnancy protection programme. And they knew where to find the safety leaflets and cards and when to issue them. The pharmacist monitored prescriptions for valproate. And they spoke to people that could be affected to confirm they knew about the risks. The company had trained the team members about the Falsified Medicines Directive (FMD) and what it aimed to achieve. And it had implemented and embedded the system in their day-to-day processes.

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 used crown-stamped measuring equipment. And the measures for methadone were highlighted, so they were used exclusively for this purpose. The team members used a blood glucose monitor. And the records showed it had last been calibrated on 12 December 2019. The team members used a blood pressure monitor. And a label showed the next calibration was due in August 2020. 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 it arranged computer screens, so they could only be seen by the pharmacy team. The pharmacy team members used portable phones. And they 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.