General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: LLoyds Pharmacy, Pharmacy Unit, Co-Operative Retail Services Ltd, 190 Crown Street, Glasgow, Lanarkshire, G5 9ZR

Pharmacy reference: 9011215

Type of pharmacy: Community

Date of inspection: 26/02/2020

Pharmacy context

This is a community pharmacy co-located with a large supermarket. 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 provides flu vaccinations and a smoking cessation service. The pharmacy moved premises in August 2020. 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	Good practice	1.2	Good practice	The pharmacy has embedded continuous improvement in its practices. The pharmacy team ensures it learns when things go wrong. And it takes its time to discuss and identify risks so that the safety and effectiveness of its services continue to improve.
2. Staff	Good practice	2.2	Good practice	The pharmacy team members complete regular training. And the pharmacy provides time during the working day to support them to do so.
		2.4	Good practice	The pharmacy team members work effectively. And they are comfortable talking about their weaknesses and the importance of shared learning. They focus on continuous improvement. And they want to provide good outcomes for people.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team manages its services to ensure they optimise efficiency and effectiveness. And it ensures its services provide good outcomes.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy team members work to professional standards. And they follow working instructions to keep services safe and effective. The team members keep detailed records about the mistakes that happen whilst dispensing. And they use this information to learn and reduce the risk of further errors. 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. The team members 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.

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 team members carried out regular weekly audits to identify and manage service risks. And this provided assurance that environmental risks were being managed and team members were up-to-date and competent in their roles. For example, a recent audit result showed that the team members had re-read the 'substance misuse' procedure following a near-miss error. 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 team members reflected on the errors to identify what the aggravating factors might have been. And they recorded the details on the near-miss record sheet. For example, when they had failed to check the contents of a pack to confirm they were dispensing the prescribed quantity. The pharmacist carried out a formal near-miss review at the end of the month. And this enabled them to identify where practices needed to improve. For example, reminding the team members to mark 'split packs' to indicate a 'part-pack'.
The pharmacy team used a notice board to highlight improvement actions that were ongoing. Such as, a list of medicines that were subject to 'risk reduction' due to near-miss patterns and trends. This included 'colchicine and cyclizine' tablets. And 'amitriptyline/amlodipine' that was described as a 'never event'. The company had introduced a new initiative to manage the risks associated with 'look-alike, sound-alike' (LASA) medicines. And the pharmacy knew about new shelf-edge caution labels and a LASA stamp to annotate prescriptions to alert the team members at the time of dispensing. A sample review showed the team members had discussed the following items at the monthly team briefing;
1. Checking prescriptions for capsule/tablet formulations due to a glitch with electronic prescriptions. The pharmacist had already discussed the issue with the surgery.
2. Managing the queue of people waiting on their medication due to an increased demand since the pharmacy's relocation. And to avoid rushing dispensing to manage the risk of dispensing errors.

The pharmacist managed the incident reporting process. And the pharmacy team members knew when incidents happened and what the cause had been. For example, when the delivery service had supplied the wrong medication. The pharmacist had carried out an investigation and found that a team member had removed two prescriptions for two different people with the same surname. And they had banded

them together to be delivered without checking the person's full name and their address. The pharmacist had made changes to avoid the same thing happening again;
1. Removing old prescription bags from the shelves to make the retrieval process safer and more effective.
2. Discontinuing the practice of banding prescription bags together. And to ensure the necessary identify checks were carried out throughout the dispensing process.
3. Attaching pharmacist stickers to prescription bags for people with the same.

The pharmacy used a complaints policy to ensure that team members handled complaints in a consistent manner. And it used a leaflet to inform people about its complaint's procedure. The pharmacy invited people to provide feedback about the services they received. And this had been mostly positive. The feedback had prompted team members to discuss waiting times. And this was due to an increase in the number of people visiting the pharmacy since its relocation. The team members had agreed to increase the waiting time when there was an increased demand for dispensing services. And they knew to suggest using the library or supermarket whilst they dispensed prescriptions.

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 weekly balance checks. 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 they used the NHS Greater Glasgow & Clyde website to access the 'pharmacy first' PGDs.

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 its consultation room. And it used the protecting vulnerable group (PVG) scheme to help protect children and vulnerable adults. The company regularly trained the pharmacy team to follow the company's safeguarding policy. And this ensured the team members knew how to handle concerns and make referrals.

Principle 2 - Staffing ✔ Good practice

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 are encouraged to identify and discuss their learning needs at regular review meetings. The pharmacy supports the pharmacy team to learn and develop. And it provides good access to structured training and development. The pharmacy team members support each other in their day-to-day work. And the pharmacy provides a positive culture of learning.

Inspector's evidence

The pharmacy workload had increased by around 2500 items per month since its relocation in August 2019. And this was due to the pharmacy's increased visibility from the health centre and by people using the supermarket. The company had employed a new part-time dispenser due to the increased demand. And it had authorised the pharmacist to send prescriptions to two off-site dispensing hubs. 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 new dispenser and the student worked extra to provide cover. The team members were mostly well-established. And they were experienced and knowledgeable in their roles. The pharmacy kept training qualifications on-site. And the following team members were in post; one full-time pharmacist, one full-time trainee pharmacy technician, one part-time accuracy checking technician (ACT), three full-time dispensers, one part-time dispenser, one full-time trainee dispenser, one pharmacy student working Saturdays and one delivery driver.

The pharmacist carried out regular performance reviews to help the team members improve and develop in their roles. For example, they had delegated responsibility to the trainee pharmacy technician who managed the prescription re-ordering processes. And this ensured that they processed prescriptions for the off-site dispensing hubs to be returned in good time. The company provided structured training. And this ensured the team members stayed current in their roles. For example, they had recently completed training about the valproate pregnancy protection scheme, Aronix, CBD Oil, the falsified medicines directive (FMD) 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 team members were responsible for managing their own time. And the pharmacist agreed authorised allocated learning time when they were up to date. The pharmacy supervisor supported the team members to complete mandatory training and assessments. And they set up the training modules in the consultation room ready for each team member to complete.

The company was in the process of training the team members to provide health screening checks for employers in the area. And this included taking blood samples to carry out simple tests. The company had arranged for the necessary controls to be put in place. And it vaccinated the team members against the hepatitis B infection to protect them. The company had trained the pharmacist to provide travel vaccinations and advice. And this was due to the pharmacy's proximity to the city centre. An ACT provided support two days per week. And they worked in other branches the rest of the week. The ACT

kept records of their checking activities. And the pharmacist in each branch carried out extra accuracy checks on 10 checked prescriptions per week. This provided the pharmacy with the assurance that the ACT maintained competency in checking.

The company used targets to grow the services it provided. For example, 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 they knew only to speak to people about services that would benefit them. The team members felt empowered to raise concerns and provide suggestions for improvement. For example, they had recently changed the way they stored multi-compartment compliance packs. And they had segregated packs for delivery and pack for collection. This made retrieval safer and quicker.

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 have a private conversation with pharmacy team members.

Inspector's evidence

The pharmacy had relocated into a larger building a short distance away from its original premises. And it was providing services from a large, 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 arranged with a separate rear area for multi-compartment compliance pack dispensing.

The main dispensary had good bench space and separate 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 a consultation room and a separate booth. And the team members used the booth for supervised services. And the consultation room for health checks and to administer vaccinations.

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 team members manage the services well. And they make changes so that services continue to improve. 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 an automatic double door provided extra support for people with mobility difficulties. The pharmacy team members displayed most of their health information leaflets in the consultation room. And they knew when to issue them to help support people. 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 attached warning labels to prescription bags when people had the same/similar names. And this managed the risk of dispensing incidents and people being given the wrong medication. The pharmacist had trained the pharmacy team to speak to people about the chronic medication service (CMS). And this helped them to provide 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 of them so that they knew when the next supply was due. The team members highlighted when people arrived too early or later than expected. And this ensured they spoke to them to find out if they were having difficulties. The pharmacist had seen to someone who had fallen over in the street. The pharmacist had found the person’s blood pressure to be very high and their weight to be below 50kg. And they had contacted the GP to advise that a medicines review was necessary in line with the person’s low weight.

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 120 people. And the company had authorised the pharmacist to send around 60 to an off-site dispensing hub. The team members had read and signed the company’s working instructions to confirm that dispensing was safe and effective. And they used an allocated area that was sufficient in size and layout to safely assemble, check and store the packs. A trainee pharmacy technician was responsible for ordering new prescriptions. And they used the PMR to identify when new prescriptions were due. The pharmacist clinically checked the prescriptions. And the team members used supplementary records to dispense into the correct compartment of the pack. The team members isolated packs when people’s prescription needs had changed/were changing. For example, when they went into hospital. And they updated the records once the changes were confirmed. The team members had introduced a sheet for people taking warfarin medication. And they updated the sheet when the nurse called to confirm each person’s dosage. The team members checked to ensure that people collected their medication on time. And this helped them to identify potential compliance issues which they referred to the pharmacist. The team members supplied patient information leaflets. And they provided descriptions of medicines to support people to take their medicines correctly. 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 pharmacy provided a managed repeat dispensing service (EXRX). And this enabled the team members to dispense prescriptions in advance of them being needed. The team members had been authorised to send prescriptions for around 150 people to another off-site dispensing hub. And they had been trained to follow the necessary procedures. The pharmacist carried out checks before the prescriptions were transmitted to the hub. And the team members carried out checks when prescriptions were returned by the hub. And this provided assurance that dispensing was safe.

The team members dispensed methadone doses for around 10 to 15 people using a MethaMeasure machine. And they obtained an accuracy check at the time of registering new prescriptions. And they obtained a final check at the time they made a supply. The team members had introduced a gold-coloured basket for controlled drug (CD) prescriptions that they had dispensed. And this ensured they carried out extra checks at the end of the day to ensure that supplies had been recorded in the CD registers.

The pharmacy purchased medicines and medical devices from recognised suppliers. The pharmacy kept stock on open shelves and in a series of drawers. And they used a separate section above the dispensing bench for fast-moving stock items. This ensured the team members continually monitored the stock, so they did not run out. The pharmacy purchased medicines and medical devices from recognised suppliers. 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 four 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 February 2020 they had acted on an alert concerning Gliclazide. And on checking the drawers they confirmed 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. But it had not embedded the system in its 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 pharmacy used a MethaMeasure for dispensing methadone doses. And the pharmacist calibrated the machine to show it was measuring accurate doses. The team members used a blood pressure monitor. And a label showed when the next calibration was due. The team members used a blood glucose monitor. And records showed the team members carried out regular calibrations.

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.