General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 16 Central Avenue, Shortlees, KILMARNOCK, Ayrshire, KA1 4PS

Pharmacy reference: 1041844

Type of pharmacy: Community

Date of inspection: 16/10/2019

Pharmacy context

This is a pharmacy in a row of shops in a suburb of Kilmarnock. It offers the usual range of Pharmacy First services as well as blood pressure and blood glucose monitoring. It dispenses medicines for people in multi-compartmental compliance packs as well as providing for people receiving substance misuse therapy, many of whom are supervised.

Overall inspection outcome

Standards not all 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 not all met	2.1	Standard not met	There are insufficient staff to safely provide the services being offered.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Arrangements for date checking of medicines are insufficient to ensure medicines remain fit for purpose.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally identifies and manages the risks to its services. It protects the privacy and confidentiality of people. And the team members are aware of how to protect children and vulnerable adults from harm. They make a record of most of the mistakes they make whilst dispensing. But they don't always complete all the information that will help them reduce the risk of a similar mistake in the future. There is a comprehensive set of written procedures to support team members. But they don't always fully follow them. And the team could do more to advertise and act on feedback they receive from people using the pharmacy.

Inspector's evidence

The pharmacy was medium sized with a good-sized retail area and a crowded dispensary. The bench and shelf space was limited and this resulted in items awaiting checking being on the floor. The checking bench overlooked the front counter and allowed effective supervision.

The pharmacy had the usual set of Lloydspharmacy Standard Operating Procedures (SOPs). These were in date and properly authorised. Pharmacy team members had last signed them in 2019 to show they had read and understood the SOPs. The pharmacy team members were mostly following the SOPs. But there were instances where they were not. Examples included not issuing balance slips to all people owed a balance of medication. Which had resulted in the above mentioned complaint. The pharmacy had not completed date checking since June 2019. And there were two boxes of out of date candesartan on the shelves. The pharmacy team members had marked the items as short dated. But they had not removed them from the shelf when expired, as per procedure.

The Pharmacy team members regularly completed the SaferCare audit. But there was a lack of review and learning from these errors. The monthly safer care board was not completed at the time of the inspection. The entry in the safer care record on 1 September 19 recorded that benches were clear and free from clutter or inappropriate items. However, this was clearly not the case on the 16 October 19 when the inspector undertook this inspection. The pharmacy had recently had a professional standards audit and similar issues were found. However Lloyds had put an action plan in place to improve the situation.

There was a regular record of near miss recording. But not all entries were complete with learnings. The number of near misses recorded during September 2019 was 14. The October total to 15 October 19 was 23. The pharmacist admitted that team members seemed to struggle to record their near misses. She had five near misses from the previous day still to record. This was for a locum dispenser who had been assembling multi-compartment compliance packs. One of the errors was an error in metformin tablets. There was one tablet missing from the pack each day for an entire week.

There was nothing in the pharmacy to inform people on how to provide feedback or complain. The last complaint had been about the incorrect supply of an amount of medicine. As a consequence team members re-read the SOP on issuing balances. And they had to ensure all balances had an owings slip issued to the person. There were no other means of promoting feedback. And there was little evidence of pharmacy team members using feedback to drive improvement.

The pharmacy had professional indemnity insurance under the Lloydspharmacy national scheme. Controlled drug (CD) records were acceptable. A check of actual versus theoretical stock showed that the figures agreed with each other. All records of patient returned Controlled Drugs (CDs) had both a pharmacist and a witness signature. The private prescription records were complete. The pharmacy made emergency supplies under the Community Pharmacy Urgent Supply (CPUS) scheme. It recorded fridge temperatures every day. And all temperatures were in the required range of two to eight degrees Celsius. The Responsible pharmacist log was complete.

No patient identifiable information was in the general waste. Or in the unlocked consultation room. The pharmacy stored confidential waste in special refuse sacks. And a contractor collected and destroyed these off-site. People waiting at the counter could not read computer screens. Or read details of prescriptions awaiting collection in the dispensary. Pharmacy team members had had training on information governance. But the pharmacy had nothing to tell people how the pharmacy would use their information.

The pharmacy had written guidance for pharmacy team members on safeguarding. And this helped them to look after vulnerable people. And team members had read this guidance and could give examples of safeguarding. The pharmacist was Protection of Vulnerable Groups (PVG) registered. And had completed the NHS Education Scotland (NES) training on child and adult protection.

Principle 2 - Staffing **Standards not all met**

Summary findings

There is insufficient pharmacist and accuracy checking technician resource to promptly check prescriptions. Team members are able to provide a range of services. But, there are signs that staffing is under pressure. These include incomplete records, an increase in the number of near misses and a general lack of tidiness. Pharmacy team members have access to a wide range of training materials and have some time in store to use these resources to develop their skills. But they are behind in their training plans due to lack of time to complete.

Inspector's evidence

On the day of inspection there were : One Pharmacist (Full Time) and two Healthcare Partners. And one pre-registration student working as a locum dispenser. There were not enough suitably qualified staff on the day of the inspection to complete the work. The pharmacist rota showed the responsible pharmacist was having to work on one of her days off that week, and that this had happened previously. There were a large number of multi-compartmental compliance packs and repeat prescriptions stored on the floor and the bench awaiting checking. This meant there was little space left to dispense walk in items and the compliance packs. This resulted in the dispensary becoming cluttered. This clutter in the dispensary, and issues with safer care and near miss records, suggested that staffing was under pressure over the longer term. Team members reported they undertook some training. But that they were not up to date with MyLearn. The pharmacy could not produce records to confirm this.

Pharmacy team members completed MyKnowledge training each month. And they had some protected time in store to complete it. Recent training was on Pharmaco-vigilance. But they also stated that they completed training at home. Team members were uncertain when their last review had been. But they reported it was over eighteen months ago. Pharmacy team members felt they could raise any concerns or ideas with the pharmacy manager. But the pharmacy manager reported raising concerns over staffing with senior managers with limited success. However, subsequent to the inspection the inspector spoke with the regional professional lead who explained Lloyds had conducted a professional standards audit, identified concerns and had an action plan in place. None of this was presented as evidence by the pharmacy. The pharmacy team members had no concerns about targets they were set for services. But they expressed concern at the loss of staff hours over the past year.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, and it has suitable arrangements for people to have private conversations with the pharmacist. The front shop is generally clean and tidy. But the benches in the dispensary are cluttered with people's prescriptions, waiting for the pharmacist to check them.

Inspector's evidence

The dispensary had no available bench space. The benches and the floor had stacks of baskets containing repeat prescriptions waiting for checking. And there were also tote boxes on the floor filled with baskets of multi-compartmental compliance packs. These also needed checking. The stacking was sufficient to raise concerns about items becoming mixed together. Or of items falling from the bench or shelves, into the baskets. At the far end of the dispensary the locum dispenser was making up multi-compartment compliance packs. But had to stop each time someone had to access the controlled drug (CD) cabinets.

There were two entrances to the building and both were at the front. One led directly into a stock area and then the back shop and dispensary. The other led directly onto the front shop sales floor. The former had a locked shutter on the outside. And containers of returned medication blocking it at the rear. This meant that pharmacy team members could not be access it in an emergency. The front shop was clean and tidy but the dispensary was very cluttered and untidy. The consultation room had a blood pressure monitor and blood glucose meter and both had a date of calibration. The room was of a small size but had a desk, chairs and running water for handwashing.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy generally uses a range of safe working techniques. These include baskets to keep items together whilst dispensing. And audit trails to track dispensing. But use of these techniques is not always consistent. And pharmacy team members don't check the expiry dates of medicines regularly, the last time being in June 2019. This increases the risk of patients being supplied with out of date medicines. The pharmacy has arrangements for dealing with medicine recalls.

Inspector's evidence

Entry to the premises was through a door accessed either by steps or a short ramp, and the counters were low in height for those in wheelchairs. There was a hearing loop on the counter for those with a hearing impairment and it was in working order. The pharmacy promoted the services it offered via leaflets in-store and posters in the window.

Stickers were in use for fridge lines and CDs awaiting collection. And to alert pharmacy team members to anyone who the pharmacist wished to speak to. Other safe working practices included the use of baskets to keep items all together. But many of these were stacked high on the floor on top of one another. This increased the risk of items becoming mixed together. Not all medicines had audit trails of 'dispensed by' and 'checked by' signatures. The pharmacist had a range of materials to provide extra information to patients who were diabetic, on warfarin or receiving valproate and there was evidence of a review of existing valproate patients.

There were a large number of multi-compartment compliance packs, with sufficient room to store them. But there was a shortage of bench space to dispense the packs. Packs had accurate descriptions of the medicines they contained. And patient information leaflets were provided at the start of each four weekly cycle. But not all compliance packs had both a ‘checked by’ and ‘dispensed by’ signature. The dispensing of the multi-compartment compliance packs was being undertaken by a pre-registration pharmacist acting as a locum dispenser. The day before this work was completed by another locum dispenser. The pharmacist reported five near misses that were yet to be written up from this work.

The pharmacy offered a delivery service and electronic records were kept of patient signatures, obtained on receipt of delivery. But it can take the pharmacist 24-48 hours for them to obtain copies of these records from AAH when there is an issue. This means that they may be unaware of a delivery problem until the patient contacts them. No deliveries were made unattended and no items were left in vans overnight. Where a patient was not at home a card would be left asking them to contact the pharmacy to re-arrange delivery.

There were records available that showed that drug recalls and alerts were regularly received and acted upon and that records of the actions taken were kept. Patients on valproate had been identified and assessed and one had required counselling. There were sufficient materials available to provide guidance to any patient presenting with valproate.

Date checking had fallen behind and had not been completed since June 19. Two boxes of candesartan with an expiry date of September 19 were still on the 'stock' shelf.

It was also noted that there were two identical prescriptions for the same patient present on the 'awaiting collection' shelves – one dated June 19 and the other October 19. The address on both was different although the patient CHI number was the same. The pharmacy team had not identified this as a potential risk, and had allowed uncollected medicines to remain on the shelves for four months, without action. The hardware needed to support the Falsified Medicines Directive (FMD) had been installed but no staff training or SOPs regarding its use had been provided. Therefore none of the features of FMD were yet being used.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has sufficient equipment for the services it offers and it keeps such equipment well maintained to provide accurate measurement.

Inspector's evidence

The pharmacy had a range of measuring equipment including a blood pressure meter which had date of first use recorded, and a blood glucose meter which had been regularly calibrated. There was also a Methameasure machine which was calibrated daily. The pharmacy had access to the British National Formularies for both adults and children, and had online access to a range of further support tools.

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.