General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 49 Rose Street, ANNAN, Dumfriesshire, DG12 5AS

Pharmacy reference: 1041999

Type of pharmacy: Community

Date of inspection: 25/07/2022

Pharmacy context

This is a community pharmacy in the town of Annan, Dumfriesshire. The pharmacy sells over-the-counter medicines, dispenses NHS and private prescriptions. And it delivers medicines for some people to their homes. The pharmacy supplies some people with their medicines in multi-compartment compliance packs to help them take their medicines. It provides a substance misuse service.

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	Pharmacy team members are in-training and often work under significant pressure to try and manage the dispensing workload. They do not have the time or skills to complete all other required tasks. And they do not always receive the support they need to complete their qualification training.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not have the necessary safeguards to adequately manage its medicines. And team members do not have all the skills they need. They do not routinely check the expiry dates of medicines and there are out-of-date medicines on the shelves. And they do not have the skills to adequately monitor the fridge temperature.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately identifies and manages risk. Team members have access to a set of written procedures to help support them in managing the pharmacy's services. Team members keep most of the records they need to by law, and they keep people's confidential information safe. Team members record details of some mistakes made during the dispensing process. But there is little evidence of any action taken by the pharmacy to prevent similar mistakes happening again.

Inspector's evidence

The pharmacy was busy at the time of the inspection. The pharmacy had introduced some measures to prevent the spread of coronavirus. These included a limiting the number of people permitted in the retail area at any one time to three. This led to some queues forming outside the pharmacy onto the street. During the inspection, some people queued for up to 30 minutes before being served by a team member. The pharmacy had a set of standard operating procedures (SOPs) for the team to use to help them complete various tasks. Team members read the SOPs in the first few weeks of their employment, and they explained they signed a document to confirm they had understood the contents of each SOP that was relevant to their role. The inspector didn't inspect records of SOPs due to the team members being behind with their workload at the time of the inspection.

The pharmacy had a process in place to record and report any mistakes made during the dispensing process that were spotted by the responsible pharmacist (RP). These mistakes were known as near misses. Team members recorded the time and date a near miss happened. And what they felt might have contributed to the mistake. They often recorded 'lack of training' or 'short-staffed' as being the reason the near miss happened. The pharmacy had an internal process to analyse the near misses each month. The purpose of this was for the team to identify any trends or patterns. And for team members to then discuss ways in which they could change the way they worked to reduce the risk of similar near misses happening again. However, the team had not completed the process for several months. Additionally, team members were often unable find the time to make a record of each near miss. And so, the team may have missed the opportunity to learn from their mistakes. The pharmacy had a process to record and report any dispensing mistakes that reached people. However, team members were unable to demonstrate how they would complete the process as they had not been shown how to do so. They explained they would look to colleagues in senior management positions for support if a dispensing incident occurred. The pharmacy had a concerns and complaints procedure. Any complaints or concerns were verbally raised with a team member. If the team member could not resolve the complaint, it was escalated to the pharmacy's superintendent pharmacist (SI) team. The team had received a significant number of verbal, informal complaints from members of the public since the beginning of 2022. Most of the complaints were around people having to queue outside the pharmacy for a significant length of time before being seen to by a team member. Additionally, the team reported having experienced various levels of verbal abuse from people who used the pharmacy who were unhappy with the service they had received.

The pharmacy had up-to-date professional indemnity insurance. The RP notice displayed the name and registration number of the RP on duty. Entries in the RP record were kept in line with legal requirements. The pharmacy kept electronic records of supplies against private prescriptions. But due to the pressure the team was experiencing during the inspection, the inspector didn't request for any

records to be seen. The pharmacy held CD registers. And the team mostly kept them in line with legal requirements. But some pages had incomplete headers.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The team placed confidential waste into a separate bin to avoid a mix up with general waste. The waste was periodically destroyed via a third-party contractor. Team members understood the importance of securing people's private information and they were provided with annual refresher training on General Data Protection Regulation (GDPR). The pharmacy had a formal procedure to help the team raise concerns team members may have about the safeguarding of vulnerable adults and children. And team members had completed some basic training on the subject. Team members described hypothetical safeguarding situations that they would feel the need to report.

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

Summary findings

The pharmacy team works under significant pressure to manage the workload. And people often wait some time to speak with a team member. Team members do not always have time to complete other routine tasks. And as they are in-training they do not always have the skills to complete all tasks they need to do. The pharmacy provides access to a structured training programme. But the team does not have the support to use it. And they do not always receive support in completing their qualification training courses to acquire the skills they need.

Inspector's evidence

The pharmacy had experienced staff changes since the beginning of 2022. This included some experienced team members leaving the business at the same time, a reported lack of locum pharmacist availability, and other long-term absences. At the time of the inspection, the pharmacy team included a locum pharmacist and three trainee pharmacy assistants. Team members were struggling to cope with the number of people who were waiting to be seen and the dispensing workload. Some people were seen to be waiting around 30 minutes to be seen by a team member. Team members explained that over the past few weeks some people had waited even longer to be served. The locum pharmacist had arrived one hour after the pharmacy had opened as he had been contacted on the morning of the inspection to work at the pharmacy and so this meant the pharmacy was behind with starting the workload that day. The pharmacy did not have a regular pharmacist and the team reported it had not been able to open for business on some occasions as there was no pharmacist. Team members explained on these occasions they had relied on more experienced team members to manage the closures. For example, informing local substance misuse service providers. But these team members had recently left the business and the team was unsure of how to manage any potential closures themselves. Team members explained they were not told if the pharmacy had arranged locum pharmacist cover for the next day. They were anxious about this as they felt they may have to face some potentially unhappy people unable to access the pharmacy's services. For example, collecting a prescription that had been dispensed. Team members were working more than their contracted hours to help complete the dispensing workload. On several occasions they started their work earlier in the morning or finished later in the evening. They often had to complete the dispensing of multi-compartment compliance packs for people while they waited in the retail area. This increased the risk of mistakes being made.

The pharmacy had a structured training programme to help support its team members update their knowledge and skills. Team members had access to an online library of modules which they could complete. Some of the modules had short quizzes for team members to complete to assess their understanding. But team members had not received any training time in recent months. The trainee pharmacy assistants were enrolled onto an appropriate dispensing course. They were previously provided with regular one-to-one reviews to discuss their progress with the course. But these reviews had stopped since the pharmacy had been operating without a regular pharmacist. Team members were not sure how much of their course they had completed and felt they would not be able to complete the course within the agreed timescales. The locum pharmacist was seen appropriately supervising the team and team members referred to the pharmacist if there was a task they were unsure about. For example, if they were unsure if an over-the-counter medicine was suitable for a

person.

The pharmacy was scheduled to have new dispensing software installed in the week following the inspection. Team members explained they were anxious about the changes as they had not received any training on how the use the software and felt the new system would cause further disruption to the dispensing process while they were inexperienced in using it. Following the inspection, the inspector spoke to the pharmacy's area manager. The area manager gave assurances the team would receive support during the transition from the old to the new software. This included the pharmacy receiving support from specialist trainers.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy services provided. It has a consultation room where people can have private conversations with pharmacy team members. The pharmacy mainly keeps its premises clean but there is some clutter on benches due to the workload.

Inspector's evidence

The pharmacy was mainly clean, well maintained, and professional in appearance. During the inspection benches in the dispensary were cluttered with baskets containing prescriptions and medicines awaiting a final check by the RP. The pharmacy's floor space was clear from obstruction. There were clearly defined areas used for the dispensing process and there was a separate bench used by the RP to complete the final checking process. The pharmacy had plenty of space to store its medicines. There was a pile of out-of-date medicines that had been taken off the dispensary shelves. These were stored loose on a bench and were not clearly marked as being out of date. Team members explained they needed to organise them and then destroythem, but had not had the time to do so. There was a private, soundproofed consultation room available for people to have conversations with team members.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

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

Summary findings

The pharmacy does not have enough safeguards in place to properly manage its medicines. Team members do not always have the time and skills to complete tasks to make sure the medicines the pharmacy supplies to people are fit for use. The pharmacy adequately manages the services it provides to people, including dispensing, to help them improve their health.

Inspector's evidence

People had level access into the pharmacy through the main entrance door. This made it easy for people with wheelchairs or pushchairs to enter the pharmacy. The pharmacy advertised its services in the main window and around the retail area. The pharmacy had a notice in the main window advising people the pharmacy would open at 10am instead of its normal opening time of 9am. There was another notice on the window explaining to people that the pharmacy was experiencing staff shortages and so there may be a delay with some services. The pharmacy had a facility to provide large print labels to people with a visual impairment. But a team member was not sure how to produce them using the dispensing software. Team members had access to the internet which they used to signpost people requiring services that the pharmacy didn't offer. Team members were asked about their knowledge of the risks of dispensing valproate to people. They were not fully sure of the risks posed to people who had the potential to become pregnant and were unaware of the Pregnancy Prevention Programme. The pharmacist was aware of the risks and demonstrated the counselling he would provide to people who were at risk. The pharmacy provided a substance misuse service to some people. The team had previously prepared instalments for people in advance. But they had not been able to do so for several weeks, and many people were having to wait while their medicines were dispensed. Team members explained this had resulted in many people moving these prescriptions to other pharmacies in the area.

Team members used various stickers to attach to bags containing people's dispensed medicines. They used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a CD that needed handing out at the same time. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. The pharmacy offered a delivery service. The pharmacy kept records of deliveries to ensure there was an audit trail.

The pharmacy supplied medicines in multi-compartment compliance packs to several people. Team members dispensed the packs in a segregated part of the dispensary. This helped team members dispense the packs away from the retail area to reduce the risk of distractions. Team members used master sheets which contained a list of the person's current medication and dose times. Team members checked prescriptions against the master sheets before the dispensing process started to make sure they were accurate. Team members were comfortable discussing any queries with the relevant prescriber. And they recorded details of any changes such as dosage increases or decreases on the person's master sheet. The pharmacy didn't supply the packs with patient information leaflets. And so, people didn't receive the full information about their medicines. The packs were supplied with some

basic descriptions of the medicines to help people identify them. For example, 'orange, tablet'. But one pack seen had three tablets in the same compartment that were described as ‘white, tablet’. Team members were aware of this issue but were not sure how they could change the descriptions.

The pharmacy stored pharmacy (P) medicines behind the pharmacy counter. It stored other medicines in their original packaging on shelves and in drawers. The pharmacy had a process in place for the team to check the expiry date of the pharmacy’s medicines. The process was to be completed every three months. But the team had not completed the process according to schedule. The team had completed checks of medicines in one section of the dispensary in the week before the inspection. Team members explained they only had the chance to do this as the pharmacy was closed for one day due to the pharmacy not having a pharmacist. The pharmacy didn’t keep any records of the process. And so, there wasn’t an audit trail in place. The inspector found nine out-of-date medicines after a random check of around 20 randomly selected medicines. None of these medicines were highlighted as being short dated. The pharmacy had one clinical-grade fridge to store medicines that needed cold storage. Team members didn’t routinely check the fridge temperature ranges as they were unsure of importance of doing so. They were unaware of how to check the current minimum and maximum temperature ranges, and what the accepted range was. During the inspection, the inspector checked the temperature ranges of the fridge. It was operating within the correct range. The pharmacy received regular updates via email of any drug alerts. Team members recorded the action they took following an alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE quality marked measuring cylinders. It stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn’t see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private. Team members had access to personal protective equipment including face masks and gloves.

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.