General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 6 - 7 Crighton Place, EDINBURGH, Midlothian, EH7 4NZ

Pharmacy reference: 1042646

Type of pharmacy: Community

Date of inspection: 29/09/2022

Pharmacy context

This community pharmacy is on the main road in Leith, a suburb of Edinburgh. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some people with their medication in multi-compartment compliance packs to help them take their medicines. And it provides the NHS Pharmacy First service.

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 generally identifies and manages the risks associated with its services. It completes the records it needs to by law and it suitably protects people's private information. The pharmacy provides its team members with training and guidance to help them respond to safeguarding concerns. They act appropriately when mistakes happen but they don't fully complete records to help prevent future mistakes and improve the safety of services.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of its services. The team members had signed to say they'd read, understood and would follow the SOPs. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred people's queries to the pharmacist when necessary.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions. For example, when the pharmacist spotted an error when completing their check of the dispensed prescription. The team members usually kept records of these errors known as near misses but no entries had been made since 26 August 2022. When they did record their near miss errors they mostly captured their learning from it and the actions they'd taken to prevent the error from happening again. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. The procedure included the team completing an electronic dispensing incident report to send to head office. The pharmacy had a process for checking the team's compliance with the SOPs and a review of errors. This process was scheduled to happen weekly but didn't always happen and when the checks were completed the outcome was not always recorded. Occasionally the pharmacist dispensed and checked their own work and to reduce the risk of errors they took a mental break between dispensing and checking the prescription. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And it had a leaflet providing people with information on how to raise a concern with the pharmacy team.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacist completed regular balance checks of CDs to help spot errors such as missed entries. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste into a labelled box before placing it appropriate bags for offsite shredding.

The pharmacy had safeguarding procedures and guidance for the team to follow and it displayed a poster advising people that it provided a safe space for people to use. The team completed safeguarding training and the RP was registered with the protecting vulnerable group (PVG) scheme. The team members had access to contact numbers for local safeguarding teams but had not had an occasion to report such concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with an appropriate range of skills and experience to support its services. Team members work well together, even under the pressure they sometimes feel.
They suitably support each other in their day-to-day work. And they have some opportunities to receive feedback and complete training so they can appropriately develop their knowledge and skills.

Inspector's evidence

A full-time pharmacist who had been in post a few weeks covered most of the opening hours with locum pharmacists covering the remaining hours. The pharmacy team consisted of one full-time dispenser who had started the week of the inspection, a full-time medicines counter assistant (MCA) and occasional support from a relief dispenser. The pharmacy was recruiting for a new team member and the pharmacy manager was due back from a planned absence.

The pharmacist reported facing some staffing challenges in the last few months after several experienced team members left the business and the pharmacy manager was on a planned absence. The team members supported each other but they had often worked under pressure especially at times when only the pharmacist and the MCA were on duty. During this time the team members reported to have struggled to manage the workload and often they were a few days behind with the processing of prescriptions. And the telephone was often left unanswered. Team members described how they were sometimes subjected to concerns directed towards them from people when there were delays to the supply of their medication. But they reported the pressures had eased since the new dispenser came into post. The pharmacist was training the MCA on the pharmacy’s IT system to obtain information such as checking the receipt of a person’s prescription. This meant the MCA could answer people’s queries without disturbing the pharmacist or dispenser.

The team members used company online training modules to keep their knowledge up to date. The pharmacy sometimes held team meetings that usually took place in the morning for planning the day ahead. The pharmacy didn’t provide team members with formal performance reviews to give them a chance to receive individual feedback and discuss their development needs. The pharmacy manager gave the team informal feedback when appropriate. The pharmacist was part of a group on a social media platform that consisted of pharmacists from other branches who shared information with each other. The area manager also used the platform to relay messages.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and generally suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were generally tidy and hygienic. In response to the COVID-19 pandemic the pharmacy team wore face masks and the pharmacy had installed clear plastic screens on the pharmacy counter. The team members used separate sinks for the preparation of medicines and hand washing and they mostly kept floor spaces clear to reduce the risk of trip hazards. Parts of the dispensing benches were cluttered with baskets piled on top of each other, creating an increased risk of errors. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had a soundproof consultation room that the team used for private conversations with people and when providing pharmacy services. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy adequately manages its services to help people receive appropriate care. It gets its medicines from reputable sources and it generally stores them properly. The team mostly carries out checks to make sure medicines are in good condition and appropriate to supply. But sometimes its processes are not robust as it doesn’t always record fridge temperatures and it doesn't keep records of its checks on expiry dates of medicines.

Inspector's evidence

As part of the response to the COVID-19 pandemic and the limited team numbers working, the pharmacy closed at lunchtime and restricted the number of people in the pharmacy to two. This requirement was clearly detailed on the front door of the pharmacy. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The pharmacy kept a small range of healthcare information leaflets and the team provided people with information on how to access other healthcare services when required. The team members wore name badges so people knew who they were speaking to. They asked appropriate questions of people requesting over-the-counter medicines and they knew when to refer to the pharmacist.

The pharmacy had up-to-date patient group directions (PGDs) which gave the pharmacist the legal authority to supply certain prescription only medicines (POMs) within the criteria of the NHS Pharmacy First service. The PGDs included treatments for urinary tract infections. The pharmacy also provided the seasonal flu vaccination service against a PGD. The small team generally worked well together to ensure the pharmacist could provide the flu service without it significantly impacting on other services such as the dispensing of prescriptions. This included supporting people to complete the necessary paperwork before they received the vaccine. The pharmacist had in-date adrenaline available to enable a prompt response when a person experienced an anaphylactic reaction to the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 32 people take their medicines. To manage the workload the pharmacy arranged for a relief dispenser to be on duty to support the team when the packs were being dispensed. The team usually ordered the prescriptions a few days in advance of dispensing the medication into the packs to allow time to manage issues such as missing items. Each person had a record listing their current medication and dose times. The team checked prescriptions against the list to identify changes, which they queried with the prescriber. The pharmacy also received a form from the team at the medical centre advising of any changes to a person’s medication. The form provided detailed information on the medication required, the change to the medication and who had requested the change. These forms were recevied for example, following a person’s discharge from hospital. The team mostly recorded the descriptions of the products within the packs and supplied the manufacturer’s packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses.
It prepared the doses for the liquid medication using a pump that was linked to a laptop. The team inputted prescription information into the system on the laptop to ensure the pump measured the required doses and generated the correct labels. The pharmacy provided several people with their medicines from NHS instalment prescriptions. The team dispensed the instalments in advance and

stored them in baskets labelled with the person's name that were kept on dedicated shelves. The team provided people with clear advice on how to use their medicines. But the pharmacist didn't record the conversations they had with people especially those on high-risk medicines on to the pharmacy's patient medication record (PMR). The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided to people. The pharmacy didn't have anyone prescribed valproate who met the PPP criteria.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. A sample found that the team completed the boxes. The pharmacy used clear bags for controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided the person with a printed slip detailing the owed item. The team asked for the person's date of birth as part of the checks to ensure the prescription was handed to the correct person. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from several reputable sources. The team members checked the expiry dates of medicines and they marked medicines with a short expiry date to prompt them to check the medicine was still in date. But they didn't always keep a record of this activity. No out-of-date stock was found. The team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team usually checked and recorded fridge temperatures each day. A sample of these records found several gaps in September, the records for the other months were complete. The pharmacy had medicinal waste bins to store out-of-date stock and patient-returned medication. And it stored out-of-date and patient-returned CDs separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had references resources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. The pharmacy computers were password protected and the computer on the pharmacy counter was situated in a way to prevent disclosure of confidential information. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area. The pharmacy stored completed prescriptions away from public view.

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.