General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 3-5 Duke Street, Leith, EDINBURGH, Midlothian, EH6 6AE

Pharmacy reference: 1042654

Type of pharmacy: Community

Date of inspection: 09/03/2022

Pharmacy context

This is a community pharmacy on a main road near two other pharmacies and shops. It is close to Edinburgh city centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. This pharmacy was inspected during the COVID-19 pandemic.

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 not all met	1.1	Standard not met	The pharmacy does not adequately identify and manage all the risks associated with its services. Team members do not follow all the standard operating procedures as they have not been given adequate time to read and understand them. This means they have gaps in their knowledge which increases the risks in their ways of working. And this is seen in the way they deliver the pharmacy's services. And in not maintaining running stock balances of some medicines requiring safe custody. This means that team members may miss an opportunity to identify potential mistakes.
		1.2	Standard not met	The pharmacy does not adequately monitor and review the safety and quality of its services. The pharmacy does not have sufficient arrangements in place to learn when things go wrong. It does not review dispensing errors and near miss errors so the team miss learning opportunities to improve patient safety.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough suitably trained and skilled team members to manage the workload and deliver all its services safely and effectively.
		2.2	Standard not met	The pharmacy does not support its team members enough with training. So they do not have the skills or competence, for their roles and the tasks they carry out.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.1	Standard not met	Some people experience barriers to accessing pharmacy services which may prejudice their care. The pharmacy is sometimes closed unexpectedly during normal trading hours, so people cannot access its services. And when the pharmacy is open, people sometimes experience a delay in receiving their medicines.
		4.2	Standard not met	The pharmacy doesn't always manage and deliver all of its services safely and

Principle	Principle finding	Exception standard reference	Notable practice	Why
				effectively, especially its dispensing service. This includes how team members manage dispensing certain types of prescriptions. And how they manage and dispense medicines in multi-compartment compliance packs.
		4.3	Standard not met	The pharmacy does not store and manage all its medicines safely due to poor stock control, untidiness and lack of fridge temperature monitoring. The pharmacy does not have a robust date checking process and it has out-of-date medicines on its shelves.
		4.4	Standard not met	The pharmacy does not have evidence that it deals with medicine recalls appropriately. And the team does not know what to do. So, people may receive medicines that are not fit for purpose.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy does not adequately identify and manage all the risks associated with its services. It does not ensure that team members follow written procedures for its services, so there is a risk of mistakes. Team members do not know how to record and review their mistakes so they cannot identify learning points. The pharmacy keeps most records as it should by law, and it keeps people's private information safe.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter, and only allowed two people on the premises at any time. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points daily.

The pharmacy had standard operating procedures (SOPs) which team members had signed. But a team member described being asked to read and sign these while she was working on the medicines' counter. And she was not trained and competent in all tasks despite signing the SOP, for example handling and dispensing controlled drugs. The pharmacy superintendent reviewed the SOPs every two years and signed them off. The only regular team member present described her role, including her dispensing limitations although she was a qualified dispenser. She knew which activities could not be undertaken in the absence of the pharmacist. The pharmacy did not manage dispensing, a high-risk activity, well. At the time of inspection, it was observed to be chaotic. The two locum pharmacists who were working opened the pharmacy late while they tried to understand the processes. The pharmacy did not have a business continuity plan to address staffing issues and disruption to services.

Team members did not routinely record mistakes. The pharmacy had a 'near miss log' to record dispensing errors that were identified in the pharmacy, known as near miss errors. But team members were not familiar with it. The pharmacy had last used it several months ago, and there was no evidence of reviewing mistakes to learn from them. The pharmacy was not undertaking other reviews or audits such as the Lloyds Safer Care audits.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2022. The pharmacy displayed the responsible pharmacist notice and kept a responsible pharmacist log. It showed several days when the pharmacy did not have a pharmacist for at least part of the day, for example a pharmacist signing in at 3pm. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. But the team had not made many records over the past few weeks. The pharmacy had a basket of private prescriptions that had been supplied and no record made. It kept unlicensed specials records and controlled drugs (CD) registers with most running balances maintained and audited. Random running balance checks identified one incorrect balance. The pharmacy had a CD destruction register for patient returned medicines. But the team had not recorded items received recently.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP. They segregated confidential waste for secure destruction. No person identifiable information was visible to

the public. Team members had also read a SOP on safeguarding. The delivery driver described examples of acting appropriately when he had concerns about people. The pharmacists were registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

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

Summary findings

The pharmacy does not always have enough competent and experienced team members to provide all its services safely and effectively. And it does not provide time, support, or resources for team members to learn. The team works hard but struggles to complete the workload.

Inspector's evidence

The pharmacy team was under a lot of pressure as it had very few team members and did not have a regular pharmacist. It had two part-time trained medicines' counter assistants (MCA), one new part-time team member who had not started any training, and one experienced delivery driver who worked across three branches. At the time of inspection there were two locum pharmacists and a medicines' counter assistant working. The MCA described how very stressed and emotional she felt due to the pressure she felt as the only regular team member working in the pharmacy. And she spent much of her time apologising to people because their medicines were not available to collect. She had completed a dispensing course but was not competent in all areas of dispensing. For example, she was not able to produce dispensing labels. And she did not check expiry dates of medicines as she dispensed them. Team members did not know how to undertake some processes in the pharmacy including the management of serial prescriptions or managed repeat prescriptions. And they did not know how to deal with medicines' recalls and ordering of 'specials'. The locum pharmacists were not familiar with this pharmacy. One pharmacist had worked in the pharmacy several months previously, but at that time there were trained team members and embedded processes. A team member from another branch helped for a short time most days. Team members were not able to manage the workload. The locum pharmacists recognised this and closed the pharmacy as they did not believe they could provide a safe pharmaceutical service. One pharmacist then worked on multi-compartment compliance packs due to be supplied that day. And the other pharmacist tried to clear the dispensing left on the bench from the previous day. The pharmacy did not provide learning time during the working day for team members to improve their knowledge or skills. And there was no evidence of learning from incidents or making improvements when team members raised concerns about staffing levels. The team did not record or discuss incidents and mistakes. So, they did not learn from each other or from their own mistakes. The company set targets for various parameters but meeting these was not currently a priority as the processes in the pharmacy were not embedded.

The regional manager, divisional manager and three experienced dispensers from other branches came to the pharmacy to help after the locum pharmacist's call to the superintendent pharmacist explaining that the GPhC inspector was on the premises.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are adequate for the pharmacy services provided. The pharmacy has appropriate facilities for people to have conversations with team members in private. But some areas are dirty, and the basement has faulty lighting and some damp.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and basement including storage space and staff facilities. The pharmacy stored some medicines including completed multi-compartment compliance packs, and baby milk in the basement. Walls in the basement were damp. This had been highlighted in the previous inspection report in 2016. There were rat and mouse traps in the basement, but no evidence of activity was seen. The team member present was not aware of regular maintenance or vermin activity. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and hand towels. Some areas of the premises were dirty, including the stairs.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and computer and the door closed providing privacy. Temperature felt comfortable throughout the premises. Lights in the basement continually flickered.

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

Summary findings

The pharmacy's services are not always easily accessible for people. And it does not always manage and deliver all its services safely and effectively. The pharmacy obtains medicines from reliable sources, but it does not store and manage all medicines properly. And team members do not all know what to do if medicines are not fit for purpose. The pharmacists support people by providing them with suitable information and advice to help them use their medicines.

Inspector's evidence

The pharmacy had good physical access by means of a small step at the entrance and a power assisted door. It listed its services and had leaflets available on a variety of topics. The pharmacy signposted people to other services such as needle exchange. Team members wore badges showing their name and role. The pharmacy provided a delivery service. The delivery driver was experienced and had read and signed relevant SOPs. But he often had to wait in the pharmacy while team members dispensed medicines and assembled multi-compartment compliance packs. This increased the risk of mistakes being made as team members worked fast and under pressure. The situation was due to a backlog of work. Previously, dispensed medicines had been ready for the delivery driver. On the day of the inspection the pharmacy did not open until 9.30am while the locum pharmacists tried to familiarise themselves with the processes and outstanding work. And they closed the pharmacy at 10.30 as they were concerned that due to the disorganisation in the pharmacy, they could not provide a safe service. They contacted the health board, the pharmacy superintendent's office, the local GP practice and the two local pharmacies that were likely to be impacted. There were queues observed at the other pharmacies. And they put a notice on the door to inform people. During the hour that the pharmacy was open, around ten people had come to collect medicines. But the pharmacy could not supply any of them initially due to the backlog of dispensing. The pharmacists and MCA prioritised these, looking for prescriptions and dispensing them. The MCA explained that the pharmacy had turned all 'walk-in' prescriptions away the previous day as there was not the team resource to manage the workload.

Pharmacy team members did not follow a logical or methodical workflow for dispensing. At the time of inspection, dispensing looked chaotic with baskets of prescriptions in different locations and little explanation of why they hadn't been dispensed. Some were observed with notes stating to leave for the dispenser from another branch who sometimes helped. One had a message to call and check a medicine with a GP as the patient had told the pharmacy that his doctor had told him not to take them. The note was not dated but referred to tablets not supplied over three weeks previously. This made it very difficult for team members on the day to provide a safe service. Team members sometimes initialled dispensing labels to provide an audit trail of who had dispensed and checked medicines. Many dispensed medicines did not have 'dispensed by' initials on labels. The pharmacy had a lot of owings. It used to assemble these the following day, before the current challenges. But sometimes it did not receive stock to enable this. Team members did not routinely undertake stock counts which caused shortages of some items and over-stock of other items. And this led to the high number of owings and created an increased workload. And it increased risk of errors in some cases. For example, a note attached to partially assembled multi-compartment compliance packs listed three different medications that were still to be added to some of the packs. This was confusing, and there was a risk of the note becoming detached. A lot of the pharmacy's dispensing was from managed repeat prescriptions. But the pharmacy was not following the correct process for these, so there were many examples of

prescriptions not being ordered on time, so medicines were not ready as people expected. This led to disappointment and frustration. Team members apologised a lot to people. An example was observed of a prescription that could not be found, but according to the computer, the pharmacy had received it the previous week.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these when people came to the pharmacy. There was no-one present who could describe this service. And no records were seen. The pharmacy still called these CMS prescriptions which was the name of the previous NHS service.

The pharmacy managed the dispensing of multi-compartment compliance packs on a four-weekly cycle. But it had a backlog of these and did not have packs prepared for supply on the day of the inspection. The pharmacy did not keep adequate records, so the process was confusing. An example was a prescription dated 03.12.21 and a pharmacy team member had written 3.1 and 31.1 on the prescription. It was not clear what these dates meant. There were three assembled packs. The pharmacy had labelled them on 03.03.22. But the backing sheets noted dates of supply as 07.02.22, 14.02.22 and 21.02.22. It was unclear when the previous pack had been supplied, and when the next pack was due for supply. The pharmacy had two prescriptions for some people, for example dated December 21 and February 22. And there was no evidence of which instalment numbers had been supplied from which prescription. This was very confusing for team members and posed a risk of incorrect supplies being made. Team members usually assembled four weeks' packs at a time, but sometimes only assembled one for immediate supply as there was not time to assemble four. Team members stored complete packs alphabetically on shelves in the basement. And they moved packs to a different location when people were in hospital to avoid these being supplied. But some packs in this location were dated 1.11.21 and 1.12.21. There were no records to clarify if these people were still in hospital. The MCAs handed compliance packs out to people and kept records of this. They used the person's name and date of supply written on to the spine of the packs. But most packs observed during the inspection did not have names or dates on the spines. This made it very difficult for team members to make safe supplies. The MCA was aware of the risk, but often there was not a team member working who was able to clarify when packs were due to be supplied. The pharmacy had until very recently provided pharmaceutical services to care homes. But the regional manager had relocated this service to another branch as the pharmacy was unable to provide a safe and effective service. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these when people came to the pharmacy. This caused some disappointment to people because they were used to their medicines being ready to collect. And it increased the risk of mistakes being made working fast and under pressure. The pharmacy had previously dispensed these prescriptions in their entirety on receipt, but currently did not have the team resource to enable this. The process looked chaotic, with stock and labels in baskets for some people, and nothing in baskets for other people.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. They supplied written information and record books if required. Team members present did not know if the pharmacy had put the guidance from the valproate pregnancy prevention programme in place. But the locum pharmacists were fully aware of this and would counsel people appropriately. The pharmacy had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. One of the locum pharmacists could not provide the chlamydia service as he did not usually work in this health board area. Pharmacists delivered the NHS Pharmacy First service and the smoking cessation service.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy

stored most medicines in original packaging on shelves, in drawers and in cupboards. But some loose strips of tablets were observed on shelves. And some shelves and cupboards were untidy. Some different tablets were stored together, some items were in multiple locations and different strengths of some tablets were stored together. The pharmacy stored items requiring cold storage in a fridge and team members sometimes monitored and recorded minimum and maximum temperatures daily. They had checked the fridge temperatures two weeks previously on 23 February. Team members last checked expiry dates of medicines in December 21 and some items inspected were short dated and out-of-date. The pharmacy protected pharmacy (P) medicines from self-selection.

The inspector did not see Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts and there were no team members present who could describe or demonstrate the process. The pharmacy returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to deliver its services. And team members look after equipment to ensure it works.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used. The pharmacy had a carbon monoxide monitor maintained by the health board to use with people accessing the smoking cessation service. But the team was not using it during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for water. And they had clean tablet and capsule counters in the dispensary which they washed after use.

During the inspection a team member discovered the fax machine had been switched off. When it was switched on, several private prescriptions were printed. And the printer was jammed so, for example shelf-edge labels could not be printed. This took a team member some time to resolve.

The pharmacy stored paper records in the dispensary and basement inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.