General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 2 Ferniehill Road, Gilmerton, EDINBURGH, Midlothian, EH17 7AB

Pharmacy reference: 1042665

Type of pharmacy: Community

Date of inspection: 03/06/2021

Pharmacy context

This is a community pharmacy in a residential area, beside other shops on a main road into the city. 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. And supplies a range of over-the-counter medicines. It offers services including smoking cessation, blood pressure measurement and diabetes testing. This pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 suitably identifies and manages the risks associated with its services, including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records it needs to by law and keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people.

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, hand sanitiser at the premises entrance, and face masks to offer to people who entered the pharmacy not wearing one. The pharmacy displayed signage and had tape on the floor to encourage people to socially distance and follow a one-way system. It allowed four people on the premises at any time and sometimes people queued outside. Most people coming to the pharmacy wore face coverings and team members all wore fluid resistant masks which they replaced several times a day. Delivery drivers also wore masks. Team members washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points first thing in the morning, last thing in the afternoon and several times during the day. A team member cleaned the consultation room immediately after use. The pharmacy manager had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. No such risks had been identified. Team members were not carrying out lateral flow COVID tests as they had not been trained by a pharmacist. The new pharmacy manager had a deadline to ensure everyone was trained and then they would do this.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them at least every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and confirmed on individuals' record cards. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. Medicines' counter team members were clear about their role and could describe their involvement in prescriptions and services such as Pharmacy First. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. Dispensing team members rotated through the different tasks to maintain their skills in all areas and avoid boredom. The pharmacist initialled prescriptions that she had clinically checked, using an 'ACT stamp' to enable an accuracy checking pharmacy technician (ACT) to safely carry out accuracy checks on some dispensed medicines. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. This included processes and contact numbers for team members to use for routine and emergency maintenance

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. On days when no errors had been identified, a team member made a note on the near-miss log. This confirmed that there was constant awareness of mistakes and the benefit of recording these. The team reviewed all near misses and errors each month and met to discuss and learn from

them. And they introduced strategies to minimise the chances of the same error happening again such as shelf edge labels highlighting similar packaging. It was noted that over the past few months there had not been many near misses recorded, including some days when there had been none. Team members believed this was an accurate reflection of their dispensing accuracy. They explained that they had been short-staffed and were aware of the risk of error this could cause. They felt that they may be taking more time ensuring accuracy. The pharmacy also carried out other audits as required by the company's 'Safer Care' programme. This involved weekly checklists covering most aspects of the pharmacy's activities each month. The pharmacy had a complaints procedure and welcomed feedback. Team members did not describe any recent complaints, and several 'thank-you' cards from people using the pharmacy were observed.

The pharmacy displayed an indemnity insurance certificate, expiring 30 June 2021. The pharmacy displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. All records were accurate and up to date. The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed company policies. 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. They knew how to raise a concern locally and had access to contact details and processes. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles and the services they provide. They know how to make suggestions and raise concerns if they have any to keep the pharmacy safe. This includes highlighting times when the pharmacy is short-staffed. Team members have access to training material and information, so they have the skills they need for their roles. They learn from incidents to avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one part-time (ten hours per week) accuracy checking technician (ACT), one full-time and two part-time dispensers, three part-time medicines counter assistants, and a delivery driver shared with other branches. The pharmacy displayed team members' certificates of qualification. At the time of inspection there were two dispensers and two medicines' counter assistants working. This was variable across the week. Team members were able to manage the workload, but they described challenges, particularly during absence and annual leave. There was no 'buffer' to accommodate absence. Recently a non-pharmacist manager who was a dispenser had left. She worked 38 hours per week and these hours had not been replaced. The pharmacist had started in the pharmacy about a month ago, after a lengthy period of no regular pharmacist in the pharmacy. Initially she did not have management responsibilities, but when the manager left, she had agreed to become the pharmacy manager. A medicines' counter assistant working 20 hours per week had also left and not been replaced. The pharmacy reviewed staffing levels and periodically made adjustments related to workload which was calculated using prescriptions numbers. The number of prescription items reported by the pharmacy had been very variable over several months. Team members were concerned for security on occasions when there were only two on the premises, some afternoons each week. There were times when dispensing team members covered the medicines' counter. They felt this was distracting, taking them away from dispensing activities, and depending on what they were doing, they were unable to watch over the counter and retail area. Two mornings per week there were three dispensers working, so they took the opportunity to undertake routine tasks including auditing controlled drugs' running balances and dispensing instalment prescriptions. The ACT worked twice a week and team members ensured multi-compliance packs had been clinically checked and dispensed ready for her to accuracy check. The dispensers had recently discussed if there may be a better work pattern to make this process more efficient, and this was being pursued. Team members were anxious about staffing the following month as key people were on annual leave including the ACT and pharmacist.

All team members were qualified for their roles having completed appropriate accredited courses. They had access to ongoing training and development, but often had to complete this in their own time at home as there was no opportunity during the working day. Some team members had not been able to access online training modules due to issues with their passwords. Team members used to have annual development meetings with the pharmacy manager to identify their learning needs, but they had not had these for a long time. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. Team members gave appropriate responses to examples posed. They explained that they discussed all issues with the pharmacist and knew how to contact the area manager and felt able to raise concerns with relevant people. The company had a whistleblowing policy that team members were aware of. Team members checked the pharmacy's email account throughout the day, and they received frequent emails with information and updates from head office and the local NHS. During the inspection, team members were observed to share relevant information routinely with colleagues. The pharmacy team discussed incidents and how to reduce risks at their weekly 'Safer Care' meetings which were documented, and notes kept in the 'Safer Care' folder.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and suitable for the pharmacy services it provides and has measures in place to minimise the spread of infection. It has suitable facilities for people to have conversations with team members in private. The premises are secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and spacious but cluttered back shop area including storage space and staff facilities. The premises were mainly clean but looked scruffy and 'tired' in places inside and out. Team members cleaned surfaces and touch points more often than before the pandemic. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in several places such as the medicines counter and beside computers in the dispensary.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. This room was small but social distancing was managed by positioning chairs in opposite corners. The pharmacy also had a separate area for specialist services such as substance misuse services, but this was not currently in use – it did not have a professional appearance. People accessed these services in the consultation room. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and advice to help them take their medicines safely. And they provide extra written information to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and team members helped people with the door if required. It listed its services and had leaflets available on a variety of topics. All team members wore badges showing their name and role which helped people using the pharmacy identify different roles. The pharmacist described sometimes writing complex dose regimes on a sheet of paper in addition to directions on the dispensing label to help people take their medicines correctly. The pharmacy provided a delivery service for dispensed medicines, and this had been well used by more people during the pandemic. The driver followed accepted infection control measures when making deliveries. Team members followed a robust process to ensure all deliveries were ready well before the driver arrived at the pharmacy. On occasions items were delayed, especially if there had been late prescribing changes. In this case team members attached a label to that day's box as a reminder that there was another item to be added. The system worked well, and people received their medicines as expected.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Team members labelled prescriptions when they came from the surgery, then placed them in baskets alphabetically to ensure they could be located quickly if a person presented at the pharmacy before their medicines had been dispensed. This did not happen often as there was clear information at the medicines' counter detailing when medicines would be ready after ordering. The team member labelling drew the pharmacist's attention to any changes in dose or new medication. They also marked prescriptions to help the pharmacist complete the final clinical and accuracy check. Typically, team members dispensed prescriptions the day after they were received. They initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

A few people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy was actively promoting this service and implementing the process. The pharmacist had carried out initial pharmaceutical care needs' assessments, as required by the service specification. As she had not been in the pharmacy long this service was in its infancy.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They were currently a few days behind that, but dispensed medicines were ready before they were needed. When there were three dispensers

working, one assembled these packs in a back room, but they did this in the dispensary if there were only two working. The dispenser sealed the packs and if necessary, the ACT opened them to carry out the accuracy check. She did this in the back room. It was laid out with items to check on one side and items to be dispensed on the other side. Team members kept comprehensive records including all medication changes with date and prescriber's name. They stored completed packs in labelled boxes on dedicated shelves in another room. When people were in hospital, team members moved their packs to a labelled area to ensure their medicines were reviewed and compared to discharge documentation before supply. Team members made the appropriate changes and recorded these and any other relevant information. The pharmacy supplied patient information leaflets with the first pack of each prescription. And they included tablet descriptions on backing sheets attached to packs. The pharmacy supplied a variety of medicines by instalment. A team member dispensed some of these prescriptions weekly. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were stored securely and alphabetically in individually named baskets. Team members dispensed some instalment prescriptions when people arrived at the pharmacy using a 'Methameasure' pump.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group. The pharmacy did not supply valproate to anyone in this group. But team members knew where the patient information was kept and explained they would supply it to any new patients as appropriate. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment, capturing patient information and symptoms on a template. This enabled all consultations to be recorded on the NHS system. They referred all requests to the pharmacist. During the pandemic pharmacists had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. The pharmacy team had now resumed seeing more people face-to-face for these services. Services such as diabetes testing and blood pressure measurement were not being promoted but would be provided if there was a need. When team members provided services in the consultation room they cleaned it after use. Team members' certificates of competence in delivering these services were displayed in the consultation room.

The pharmacy obtained medicines from licensed wholesalers such as AAH and Alliance. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items and obsolete items. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and

safety alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They 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. Pharmacy team members look after this 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 kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services in normal circumstances. This included a carbon monoxide monitor maintained by the health board, a blood pressure meter which was replaced as per the manufacturer's guidance, and blood testing equipment calibrated as per guidance. The team was not using this equipment during the pandemic to reduce the chance of spreading infection. Team members kept a range of crown-stamped and ISO marked measures by the sink in the dispensary, and separate marked ones were used for water. The pharmacy used a 'Methameasure' pump for measuring methadone solution. Team members cleaned it at the end of each day and poured test volumes each morning. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and back-shop areas 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.