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: 16/03/2022

Pharmacy context

This is a community pharmacy in a residential area, beside other shops on a main road into central Edinburgh. 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 and sells a range of over-the-counter medicines. 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 are working under pressure and do not always have time.
		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 all the skills or competence required to deliver all the pharmacy's services. And it does not provide training to new team members.
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 effectively, especially its dispensing service. This includes how team members manage and dispense medicines in multi-

Principle	Principle finding	Exception standard reference	Notable practice	Why
				compartment compliance packs.
		4.3	Standard not met	The pharmacy does not store and manage all its medicines appropriately due to poor stock control, and lack of fridge temperature monitoring. The pharmacy does not have a robust date checking process and it has out-of-date dispensed medicines in retrieval areas.
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. Pharmacy team members do not always follow written processes so there is a risk of mistakes. They have made some mistakes and not recorded or reviewed them. So, they cannot identify learning points and make improvements to pharmacy services. The pharmacy keeps the records it needs to by law, and it keeps people's 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, and restricted access to one person at a 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. Early in the pandemic 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.

The pharmacy had standard operating procedures (SOPs), some of which were followed. Team members could not follow all processes and complete all tasks in line with the SOPs due to being short-staffed, so under pressure. Examples of SOPs they did not follow included date checking, audits of medicines' running balances, daily fridge temperature monitoring, timely assembly of multi-compartment compliance packs and dealing with uncollected dispensed medicines. Pharmacy team members had read the SOPs, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and confirmed by the sign-off records. Team members described their roles and accurately explained which activities could not be undertaken in the absence of the pharmacist. They gave recent examples of not undertaking certain tasks when there had not been a pharmacist signed in. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. Although there had been a lot of disruption to services recently due to a lack of pharmacist and insufficient team members working. And an ongoing electric fault was negatively affecting how some prescriptions were managed.

Team members did not record dispensing errors that were identified in the pharmacy, known as near miss errors. Up until September 21 (six months ago), these were recorded and reviewed to learn from. But team members did not have time to do this currently. The experienced dispensers present during the inspection described frustration at not being able to do this. They explained that locum pharmacists always highlighted errors to them, and they openly shared these with other team members to learn from them. The pharmacy had not carried out Lloyds safer care audits for several months. So, the team was not able to identify areas to address to improve services.

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 had not had a pharmacist for part or all day. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. But the team had not

recorded some recent prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained but not audited over the past few weeks in keeping with the SOP. It had a CD destruction register for patient returned medicines.

Pharmacy team members were aware of the need for confidentiality and had 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. They knew how to raise a concern and had information readily accessible. The pharmacy had a chaperone policy in place and displayed a notice telling people this. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

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

Summary findings

The pharmacy does not have enough experienced and competent team members to safely provide its services. And it does not provide time or resources for team members to keep their knowledge and skills up to date. This could affect how well they care for people and the advice they give. Team members use their professional judgement and make decisions within their competence to try and provide a safe and effective pharmacy service.

Inspector's evidence

The pharmacy had one full-time and one part-time dispensers, two part-time medicines counter assistants (MCA), an untrained Saturday only team member and a part-time delivery driver. The pharmacy displayed certificates of qualification. The untrained team member had worked in the pharmacy for around six months, so should have been undertaking an accredited course. The pharmacy was required to register new untrained team members on an appropriate course within three months of them commencing the role. The other team members were experienced and had worked in the pharmacy for several years. But the pharmacy was not providing them with time or resources to keep up to date or develop their skills and knowledge. This meant that the pharmacy could not provide some services that it previously had, because some team members were not trained to deliver them. Trained team members had left the pharmacy over the past few months.

The pharmacy had not had a regular pharmacist for several months and was relying on a variety of locum pharmacists. The pharmacist rota on the computer showed that there was no pharmacist arranged for the next day (Thursday) or Saturday of that week. At the time of inspection, a locum pharmacist, the two dispensers and an MCA were working.

Team members were observed going about their tasks in a calm, systematic and professional manner. But they were not able to manage the workload. Examples demonstrating this included people's dispensed medicines not ready when they and the delivery driver came to collect them. This had resulted in people's medicines being supplied a few days late, meaning they were without their medicines. Team members were observed to be prioritising tasks and dispensing to try and ensure people received their medicines on time. And all team members discussed and shared the workplan for the day. Several routine administration tasks were not done, including counting prescriptions and submitting them for processing to the NHS. One dispenser was due to finish at lunchtime, and a dispenser from another branch was expected to help in the afternoon. But she arrived during the morning. She had received a phone call asking her to come early due to the GPhC inspection being underway. The locum pharmacist working in the other branch was concerned that it was left short-staffed.

Eight months previously at the time of the last inspection the pharmacy had a larger team, including a full-time pharmacist, a part-time accuracy checking pharmacy technician, another part-time dispenser, and another part-time MCA. And that level of staffing had been challenging at times. A few weeks previously all but one part-time team members had been absent due to annual leave or illness, leaving locum pharmacists alone or working with one team member. The pharmacy had not kept up with routine dispensing, and examples were described of people not receiving their medicine. Team members raised concerns with the area manager about staffing levels. Sometimes he worked in the

pharmacy to help. And he arranged help from other branches when possible. But it was very challenging as most branches in the area were very short-staffed and several did not have a regular pharmacist.

The company set targets for various parameters, but team members did not have time to consider these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are adequate for the pharmacy services provided. It has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary, office, storage space and staff facilities. The premises were mainly clean but looked scruffy and tired in places. 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 for team members to use. There had been a recent electrical fault which was not yet resolved. Team members reminded the area manager who was pursuing this with the maintenance department.

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. The pharmacy also had a separate area for specialist services such as substance misuse services, but it was not in use. People accessed these services in the consultation room. Temperature and lighting felt comfortable.

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. 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 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 pharmacy provided a delivery service, but a team member described four consecutive days a few weeks previously when medicines were not ready for delivery. So, some people had been without their regular medication. The delivery driver explained that this did not occur when the regular team members were working as they prioritised the dispensing workload. Over recent weeks the pharmacy had not always been open as people expected due to a lack of pharmacist or support staff. For example, on 5 March, there had been no pharmacist so medicines could not be dispensed, supplied, or sold. This meant that some people did not receive their regular medication, including vulnerable people. The only team member had left the pharmacy in the interest of personal safety. The pharmacy was routinely using the health board authorised closures to help manage workload. So it was closed for the first hour of the day, the last hour of the day and an hour at lunchtime. Although people could not access the pharmacy's services during these times, team members had an opportunity to catch-up with some back log of dispensing.

There had been posts on social medica (seen by the inspector) that the pharmacy was closing for good in two days' time. During the inspection two GP practices, and several members of the public phoned to ask what the pharmacy was putting in place for continuity of pharmaceutical care. And most people who came to the pharmacy during that time also asked. Team members were re-assuring people that the pharmacy was not closing. The previous week a GP practice had withheld prescriptions as they were concerned that people would not get their medicines from this pharmacy. This situation was causing worry and distress to people and team members. And negatively impacting workflow as team members spent time trying to reassure people.

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. But routine dispensing was behind. When the pharmacy received prescriptions a team member scanned them and filed them alphabetically. This meant that if they were not dispensed when people came to collect their medicines, a team member could locate the prescription quickly and dispense it then. At the time of inspection, team members were prioritising this. There was a large volume of prescriptions to be dispensed and the team were labelling prescriptions from three days ago. The labelling process triggered stock ordering. So, delayed labelling meant that stock may not be available, further delaying the dispensing process. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy used to assemble owings later the same day or the following day using a documented owings system. But many owings' prescriptions were observed, some dating back to the middle of January and some with dispensing

labels, not owings information. The team had been told not to set up 'owings' on managed repeat prescriptions but generate labels. The team members did not know if stock was ordered or expected for these because they were not carrying out stock checks as they should according to the SOP. Some routine dispensing was carried out at an off-site dispensing hub following a defined process in a SOP. But a recent electric fault had caused a malfunction of electronic transfer of prescription information, so the pharmacy was not able to share the prescriptions with the hub. The team's dispensing workload was markedly increased if it had to dispense all these items, so team members had been faxing copies of the prescriptions to the hub. Sometimes the fax was unclear, making it difficult to read or scan, so the hub was unable to dispense some of these items. This led to an increased workload in the pharmacy. And team members were in the process of confirming if faxing was appropriate in terms of data confidentiality. Team members segregated prescriptions with queries to be dealt with later. There were a lot of these prescriptions in five baskets, many from a week the previous month when all regular team members had been off work.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy usually dispensed these before they were due to be supplied to ensure medicines were ready for people. But during this period of challenge sometimes the team members did not manage to dispense before people came to the pharmacy. But they filed prescriptions logically so could locate them quickly and dispense at that time. They kept records of when people had collected their medicines and when their next supply was due and filed the prescriptions accordingly. Pharmacists were not carrying out pharmaceutical care needs' assessments as required by the service specification.

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 or two weeks before the first pack was due to be supplied. But due to the staffing challenges this was currently not possible. At the time of inspection (Wednesday), the team had not assembled the packs for supply the following week. This increased the risk of mistakes due to working under pressure. And sometimes to minimise the time spent, only one pack was assembled rather than all four. This then increased the back log of dispensing work. Team members kept records of medicine changes, hospital discharges and other information.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. 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. Some locum pharmacists were not signed up to these in this health board area but could provide the service immediately after signing if they had completed training. The locum pharmacist present during the inspection was signed up to them all. 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. They referred to the pharmacist as required. The pharmacy was not providing other services due to staffing pressures and a lack of trained team members. It had stopped the needle exchange service due to the lack of team members. Team members present believed the pharmacy had informed the health board as this was a locally agreed service.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. The pharmacy stored items requiring cold storage in two fridges and team members usually monitored and recorded minimum and maximum temperatures daily. They had not done this for a few consecutive days on several occasions over the past few months when key team members were not working. There was no evidence of temperatures being out-with the recommended range on these days. This would have been identified the next time the minimum and maximum readings were taken. Team members did not regularly check expiry dates of medicines. The dispensers explained that they were highly aware that they were not undertaking this task so carefully checked expiry dates as they dispensed. Some items that had been dispensed several months ago and not supplied, were observed to be out of date. The pharmacy usually removed dispensed items from retrieval locations after four weeks. But this had not been done recently and a lot of dispensed medicines from several weeks and months ago were observed. This included an antibiotic for a child from August 2021, inhalers from June 2020, and instalments from May and June 2021 so the prescriptions had now expired meaning supplying these items now would not be lawful. 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. And the team mostly looks after it 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. 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 which had not been calibrated for several months. The team was seldom using this equipment as there were very few team members trained to deliver these services. Team members kept crown-stamped and ISO-marked measures by the sink in the dispensary, and separate marked ones were used for water. The pharmacy used an automatic pump for measuring methadone solution. Team members cleaned it at the end of each day and poured test volumes each morning when they set it up. 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 areas of the premises 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.