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: 18/05/2023

Pharmacy context

This is a community pharmacy in a residential area, beside other shops and on a main road into central Edinburgh. It dispenses NHS prescriptions including supplying some 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 it supplies and sells a range of over-the-counter medicines.

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	1.2	Standard not met	The pharmacy team does not have robust arrangements in place to learn when things go wrong. And team members do not take action to learn from their mistakes and reduce the risk of further errors.
2. Staff	Standards not all met	2.1	Standard not met	There are periods of time where the pharmacy does not have enough suitably trained and qualified staff for the pharmacy to operate safely and effectively. And team members do not always keep key tasks up to date, including reading the pharmacy's written procedures, checking expiry dates and recording fridge temperatures.
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 not all met**

Summary findings

Pharmacy team members do not always assess the safety and quality of services provided. They do not have complete records of mistakes they make. And they do not proactively take action to reduce the risk of similar mistakes happening. Team members follow a documented business continuity plan if the pharmacy is unable to open. They keep people's private information safe. And they have adequate knowledge to help protect vulnerable people.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). They covered tasks such as the dispensing process, responsible pharmacist (RP) requirements and record keeping in the pharmacy. The pharmacy superintendent reviewed them every two years and authorised them. Not all team members had signed to confirm they had read the SOPs and agreed to follow them. Team members described their roles within the pharmacy and the processes they were involved in and accurately explained which activities could not be undertaken in the absence of the responsible pharmacist. The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members described the process they would follow for closing the pharmacy when there was no responsible pharmacist available. This included displaying a notice with details of the nearest open pharmacy and a planned re-opening time.

The pharmacy had a "near miss log" to record dispensing mistakes that were identified in the pharmacy, known as near misses. But the last entry was from over two months previously and the entries recorded only basic details of the error. Team members described making more recent near misses, and not having time to complete the record. From the limited records, there was evidence of similar types of error repeatedly occurring. And there was no consideration of any contributing factors or learnings. They could not describe any actions that had been taken following errors to reduce the risk of a recurrence. Team members did not share information with the rest of the team when they noticed medicines with similar packaging or with short dates. So there were no systems in place to help learning from errors. Team members were not aware of how to access records of any dispensing errors identified after people received their medicines. The pharmacy's SOP showed that a "Safer Care Review" meeting to discuss dispensing incidents and patient safety audits should be completed monthly. But it was last completed ten months ago.

The pharmacy had a complaints procedure. The team explained how they dealt with concerns. They gave examples of complaints from people coming into the pharmacy and written online about not being open on time and delaying access to prescriptions. The pharmacy had professional indemnity insurance in place and displayed the correct responsible pharmacist notice. But the responsible pharmacist record showed entries missing on multiple dates when the pharmacy was open. It also showed several days when the pharmacy had not had a pharmacist for the full day. From the records seen, it had accurate private prescription records including records of emergency supplies and veterinary prescriptions. The pharmacy kept records of unlicensed medicines obtained but not who they were supplied to, meaning there was not a complete audit trail. The pharmacy kept controlled drug (CD) records. Each preparation had its own register with running balances. The SOP indicated stock balances were to be checked on a weekly basis but the most recent checks were around once per month, reportedly due to staffing pressures. During the inspection, the balances of three randomly selected controlled drugs

were checked and were correct.

Pharmacy team members were aware of the need for confidentiality. They clearly separated confidential waste and this was taken away for secure destruction centrally. No person identifiable information was visible to the public. The pharmacy had a documented procedure to help the team raise any concerns they may have about the safeguarding of vulnerable adults and children. But not all team members were aware of it. A team member explained the process they would follow if they had concerns and would raise these to the RP. But team members did not know how to raise a concern locally, or how to access contact details and processes. The pharmacist was registered with the protecting vulnerable group (PVG) scheme and was aware how to obtain local safeguarding contact details if required.

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

Summary findings

Pharmacy team members have the skills to provide the pharmacy's services. But team members are working under pressure and some key tasks remain outstanding. And for periods of time there are not enough suitably qualified staff to operate safely and effectively. The pharmacy does not provide time or resources for team members to keep their knowledge and skills up to date. Team members use their professional judgement and make decisions within their competence to try and provide a safe pharmacy service.

Inspector's evidence

The pharmacy employed one full-time and one part-time dispenser, a full-time non-pharmacist manager, two part-time medicines counter assistants, and a part-time delivery driver. The team had changed since the last inspection, and a number of team members had started working in the pharmacy within the last six months. The pharmacy team was often working under pressure due to long-term absence. The pharmacy had not had a regular pharmacist for several months and locum pharmacists were working as the RP.

Team members were seen to be working under pressure to ensure medication was dispensed on time for when people needed it. They explained the pharmacy had on some occasions closed over lunchtime to ensure the pharmacy was able to continue to operate safely with the number of team members available. The pharmacist advised they had recently signposted a person requesting a consultation to a nearby pharmacy, as they did not have the capacity to safely carry out the consultation in addition to managing the outstanding prescriptions required that day. Team members did not always answer the telephone reporting this was due to the volume of dispensing to be completed. People's prescriptions were not always ready when they came to collect them and some people called back repeatedly. The team reported that the pharmacy had opened over an hour and half late on the day prior to the inspection because the pharmacist arrived late. And the RP record showed a number of days when the pharmacy had opened late. This was reportedly due to not having a pharmacist available.
They described little time for stock control, with the last date check record being from more than four months ago. And the fridge temperature last recorded fifty days ago. Some parts of the dispensing area was cluttered and was used for storage of pharmacy sundries, expired medicines and bags of uncollected medication. Shelving to store assembled packs was kept generally neat and tidy.

On the day of inspection there were two dispensers and a medicines counter assistant working with a locum pharmacist. Team members spoken to on the day of the inspection were qualified for their roles and were experienced having worked in other pharmacies for several years. The pharmacy did not provide protected time to undertake regular training and development. They had not had an annual appraisal and were not able to describe or demonstrate records of any training recently completed. Newer team members had not been provided with time to read and sign SOPs since starting in their roles. One team member explained they had completed some of the company’s training modules in their own time at home. Team members had the training and experience to ask appropriate questions when supplying over-the-counter medicines 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. They gave examples of arranging alternative prescriptions for items that were out of stock or unavailable. This included using a different manufacturer or using a

different strength of tablet to provide the same dose. Pharmacy team members explained they would raise concerns to the regional manager who arranged help from other pharmacies in the company when possible. The team had not had any recent team meetings. The company had a whistleblowing policy that team members were aware of.

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 and a separate area including storage space and staff facilities. The premises were generally clean and well maintained. But there were areas in the back shop where stock was disorganised and cluttered. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions.

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. The room was clean and tidy, and the door closed which provided privacy. Storage in the consultation room was kept locked to prevent unauthorised access. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members make appropriate checks when they hand out medicines, to make sure people receive appropriate care. The pharmacy supports people by providing them with suitable information and advice to help them use their medicines. It obtains medicines from reliable sources, but the team has fallen behind with the completion of some key checks that make sure medicines are in date and suitable to supply.

Inspector's evidence

The pharmacy premises had physical access by means of a level entrance and team members explained they would help people using wheelchairs or with pushchairs to open the door. The central pharmacy counters were low in height for those using wheelchairs and there were leaflets available on a variety of healthcare topics. The pharmacy advertised some of its services and its opening hours in the main window.

Team members followed a methodical workflow for dispensing. 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 located the prescription quickly and dispensed it then. Team members used baskets to separate people's medicines and prescriptions. They used coloured alert labels to attach to prescriptions containing people's dispensed medicines. They used these when they handed out medicines to people, for example, to highlight interactions between medicines or the presence of a fridge line or a CD. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked the prescriptions.

The pharmacy supplied medicines in multi-compartment compliance packs to people that needed extra support with their medicines. The pharmacy had moved the dispensing of some of these packs to another pharmacy within the company nearby to reduce workload pressure. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. But packs being assembled on the day of inspection were still to be completed and checked by the pharmacist and due to be delivered the next day. Team members found it a challenge to prioritise between this and prescriptions waiting to be dispensed. They kept master backing sheets for each person for each week of assembly. These master backing sheets recorded people's details, current medication and administration times. Records of changes to medication were observed. Packs were labelled clearly with directions and descriptions. They were dispensed in a separate area of the dispensary. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these in advance of people collecting. Team members kept records of when people had collected their medicines. But there were a number of bags of medicines which had not been collected as expected. Some prescriptions had been sitting for over four weeks. This meant it was difficult to know if the person's doctor had made changes since being checked. Team members requested new prescriptions when all instalments were complete. But they did not consult with people when handing over the last instalment to identify any care issues or prompt a review by the person's doctor.

The pharmacist undertook clinical checks and explained they provided advice and counselling to people receiving higher-risk medicines including valproate. They did not record these consultations on people's records. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. 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 protected pharmacy (P) medicines from self-selection to help ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. The pharmacy stored medicines requiring cold storage in a fridge. But team members did not monitor or record minimum and maximum temperatures daily as detailed in their SOP. The last documented check was fifty days ago. There was no evidence of temperatures being out-with the recommended range on the records and the temperature was within range on the day of the inspection. Team members were aware of what action to take if temperatures went above or below accepted limits. The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves, in drawers and in cupboards. Team members explained they had not been regularly checking expiry dates of medicines. There were no records of checks for more than four months. Team members explained they were aware that they were not undertaking this task so checked expiry dates as they dispensed. The inspector found a number of medicines on the shelf that had expired. The pharmacy had disposal bins for expired and patient-returned stock. But these items had not been sorted recently and obsolete items were stored in various areas of the dispensary. This included out-of-date liquid supplements stored next to regular stock, and uncollected prescriptions in both the compliance pack dispensing area and next to the delivery bench. This created a risk of medication being mixed up. Team members were able to describe receiving Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts electronically. But they did not keep records if they had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people's private information.

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 access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

The pharmacy kept some equipment required to deliver pharmacy services, such as a blood pressure monitor and weighing scales, in the consultation room where it was used to provide its services. Team members kept crown-stamped measures by the sink in the dispensary for measuring liquids. They used an automated pump on a daily basis for measuring doses of substance misuse medicines. Team members cleaned it at the end of each day and poured test volumes daily. It was fully calibrated annually. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in an office inaccessible to the public. It stored prescription medication waiting to be collected in drawers that protected people's information from unauthorised view 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.