General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 26 Westerhailes Centre, EDINBURGH, Midlothian, EH14 2SW

Pharmacy reference: 1042754

Type of pharmacy: Community

Date of inspection: 02/08/2022

Pharmacy context

This community pharmacy is in a shopping centre in a large Edinburgh suburb. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. The pharmacy offers the NHS Pharmacy First service and it provides a needle exchange service.

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 generally identifies and manages the risks associated with its services. It protects people's private information and keeps the records it needs to by law. The pharmacy has up-to-date written procedures for team members to follow to help ensure they provide pharmacy's services safely. They have training and guidance to help them respond to safeguarding concerns and protect vulnerable people. Team members act appropriately when mistakes happen. But they don't fully complete records of mistakes to help them learn and improve the safety of services.

Inspector's evidence

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

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions, known as near misses. It had a record for the team to capture these errors but entries were only seen for June 2022 and July 2022. The team members recorded the cause of the near miss but they didn't record their learning from it and the actions they'd taken to prevent the error happening again. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. This included the team completing an electronic dispensing incident report to send to head office. The pharmacy completed weekly checks of the team's compliance with the SOPs. The outcome from the weekly checks fed into a monthly team briefing that included a review of the near miss errors. The team kept notes from the briefings that detailed the discussions held and who in the team had attended. At a recent briefing the manager discussed the importance of team members fully completing the near miss records. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. In response to complaints regarding delays with the supplies of prescriptions the pharmacy manager identified factors that often led to the delay. This included the time taken for the team to contact the prescribers about a prescription. So, the manager had arranged for a separate contact number to be provided so the team could manage queries more efficiently.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacists regularly checked the balance of CDs to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of records for the receipt and supply of unlicensed products met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had completed training about the General Data Protection Regulations (GDPR) and the pharmacy displayed a privacy notice. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The RP was registered with the protecting vulnerable group (PVG) scheme. The team members had access to contact numbers for local safeguarding teams but had not had an occasion to report such concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has a team with the appropriate range of experience and skills to safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They discuss ideas and identify ways to support the effective delivery of the pharmacy's services. The team members have some opportunities to complete training to develop their knowledge and skills.

Inspector's evidence

A part-time relief pharmacist and locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time trainee dispenser who was the pharmacy manager, two full-time dispensers, a full-time locum dispenser and two part-time pharmacy assistants. At the time of the inspection the relief pharmacist and all team members except one of the pharmacy assistants were on duty.

The pharmacy had faced some staffing shortages in the last 12 months after several experienced dispensers left the business. The two full-time dispensers started working in February 2022 and April 2022. The locum dispenser had provided support since August 2021 and in the first few months often worked alone with the Responsible Pharmacist (RP). On some occasions the pharmacy had closed for a few hours as there was no pharmacist or no team members to work with the RP. The pharmacy assistant described how the pharmacy team had been struggling to manage the workload and often there were queues of people waiting to collect their prescriptions. The team reported the pressures had eased since the pharmacy manager, who had experience from other retail sectors, came in to post in May 2022. The two full-time dispensers were at university and would be reducing their hours in September and the locum dispenser had only extended their bookings for three months. This meant there was a risk of continuing instability of staffing. The pharmacy manager was aware of this and had arranged a meeting with the area manager.

The pharmacy manager had recently met with the team at a local medical centre. The meeting was an opportunity to introduce himself and to identify ways the two teams could work together. This included a request by the pharmacy manager for the team at the medical centre to clearly advise people that their prescription had been sent to the pharmacy and not that it was ready to collect at the pharmacy. The locum dispenser had also established a working relationship with the team at the medical centre particularly the pharmacist. The pharmacy manager wanted to improve people's access to the pharmacy's NHS services such as the medicines care and review (MCR) service and the Pharmacy First service. Many of the prescriptions the pharmacy dispensed were presented by people as walk-ins. This impacted on the team member's workload as they couldn't plan in advance for the volume of prescriptions that would be presented. The pharmacy manager was keen to work with the team at the medical centre to identify people who would benefit from using the MCR service and to help the team manage its workload.

The pharmacy had changed its IT system in May 2022, two weeks after the pharmacy manager started in post. The team members had completed internal online training modules and a company trainer had provided onsite support and training for four days after the upgrade. One of the dispensers had spent time at another pharmacy that already had the system installed. The team member had learnt how the team managed the new system especially any issues they'd experienced. So, they could provide support

to colleagues. On the day of the inspection the system was operating very slowly which impacted on the team's ability to efficiently dispense prescriptions. To manage this the team members advised people of the time it would take to dispense their prescriptions. So, they had the chance to wait or call back.

The team members used online training modules to develop their knowledge and skills. And they had some protected time to complete the training. The pharmacy manager provided basic training to the pharmacy assistants on services such as MCR and Pharmacy First. This meant they could provide advice to people about the services and identify people who would benefit from them. The team held regular meetings and team members suggested changes to processes or new ideas of working. The locum dispenser and the RP had worked together to implement procedures to efficiently manage the workload of dispensing the compliance packs. And had trained the team on the procedures to help ensure the preparation of the packs wouldn't be affected by issues such as absences in the team. The team also worked together to manage the workload such as having a separate team to dispense walk-in prescriptions.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had separate sinks for the preparation of medicines and hand washing. It had installed plastic screens on the pharmacy counter to protect the team from the COVID-19 virus and it had a large retail area to enable people to stay some distance from each other. The room temperature in the pharmacy was warm, the team explained the pharmacy was warm most days. There was no air-conditioning but the team had electric fans located at different sections of the dispensary.

The team generally kept floor spaces clear to reduce the risk of trip hazards. The team focused on putting away stock received from the wholesalers soon after it arrived. This reduced the number of boxes on the floor and enabled the team to prioritise the dispensing of prescriptions that were awaiting stock. The pharmacy had a defined professional area and items for sale in this area were healthcare related. It had restricted access to the dispensary during the opening hours. The pharmacy had a soundproof consultation room which the team used for private conversations with people. The pharmacy also had a separate, cordoned off area that provided privacy to people receiving their medication as a supervised dose or accessing the needle exchange service.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which support people's health needs and it manages its services well. The pharmacy supports local healthcare initiatives to help people access appropriate care. It keeps detailed records to help monitor the services it provides and to enable the team to deal with queries effectively. The pharmacy gets its medicines from reputable sources and it stores them properly. The team members carry out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy from the shopping centre. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role so people using the pharmacy knew who they were speaking to. The pharmacy provided NHS services such as emergency hormonal contraception, smoking cessation and treatments for urinary tract infections against patient group directions (PGDs). The PGDs gave the pharmacist the authority to provide the medication.

The pharmacy provided several people with their medicines from NHS instalment prescriptions. The team dispensed the instalments in advance and stored them in baskets labelled with the person's name. The baskets were stored on dedicated shelves but in some sections the baskets were stored on top of each other. This meant it may be difficult to find people's prescriptions or the bags may move between the baskets, creating a risk of error. The pharmacy manager was aware of this and was creating more space to hold the baskets. The team marked the bag with the date of supply and attached a sticker to the bag holding the prescription's last supply. This prompted the team to ask the person to order their next prescription, to ensure the pharmacy received it in sufficient time to dispense the next set of instalments. The team reported the recent IT system change hadn't been adapted to manage instalment supplies that weren't daily. For example, when the prescription requested alternate days. The team had worked together to establish how to process instalment prescriptions with such directions. The team members provided people with clear advice on how to use their medicines and they were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP).

The pharmacy provided multi-compartment compliance packs to help around 54 people take their medicines. To manage the workload the team divided the preparation of the packs across the month and kept a record of the completion of tasks such as the ordering of prescriptions. The team usually ordered prescriptions in advance of dispensing the medication into the packs. This allowed time to deal with issues such as missing items and the dispensing of the medication into the packs. Each person had a record listing their current medication and dose times. The team checked this record against the prescriptions to identify changes or new medicines. The pharmacy received a form from the team at the medical centre advising of any changes to a person's medication. The form provided detailed information on the medication, the change and who had requested the change, for example following the person's discharge from hospital. The team mostly recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The pharmacy prepared the doses using a pump that was linked to a laptop. The team inputted prescription information into the system on the laptop to ensure the pump measured the required doses and printed labels. The pharmacy provided a needle exchange service and the sections holding the items to be supplied were organised to enable the team to easily access the items requested by the person. The team encouraged people to return the bins containing used needles to the pharmacy for safe disposal, but this didn't always happen. The person placed the bin directly into an appropriate waste bag embedded in a sealed unit so the team didn't handle it. The pharmacy also provided take-home naloxone kits to those supporting people at risk of an opioid-related overdose. The pharmacy clearly displayed in the area where people presented for the needle exchange service information such as safe techniques for injecting. And the pharmacy manager had arranged with the team from the local drug and alcohol service to hold a session at the pharmacy to provide people with advice and support.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample found that the team completed the boxes. The pharmacy used fridge and controlled drug (CD) stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept the original prescription to refer to when dispensing and checking the remaining quantity.

The pharmacy obtained medication from several reputable sources. The team checked the expiry dates on stock and recorded this on the section that had been checked. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The team checked and recorded the temperatures for the two fridges each day. A sample of these records found on a few days, including the day of the inspection, the maximum temperature for one fridge was 10 degrees Celsius. The pharmacy manager was aware of this and explained the readings were taken after the fridge had been open for a short time. On these occasions the pharmacy manager had taken additional temperature readings and found they were within the correct range but he had not recorded them. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned CDs separate from in-date stock in a CD cabinets that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

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

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.