General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 286 High Street, LINLITHGOW, West Lothian, EH49 7ER

Pharmacy reference: 1043062

Type of pharmacy: Community

Date of inspection: 30/09/2019

Pharmacy context

This is a busy community pharmacy beside a health centre. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs and provides substance misuse services. And it offers flu vaccination.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to undertake all tasks and deliver services safely.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not always manage medicines well due to untidy drawers, untidy fridges and team members do not always use clean equipment when handling medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team members follow written processes for the services it provides. They record some mistakes to learn from them. And they review these and make changes to avoid the same mistakes happening again. The pharmacy keeps the records that it needs to by law and keeps people's information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, 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 records of competency. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy recognised dispensing as a high-risk activity and used different coloured baskets to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services.

Team members sometimes used near miss logs to record dispensing errors that were identified in the pharmacy. But few entries were observed e.g. from 18.09.19 – 30.09.19 only three near misses were recorded, one on each of three days. Team members acknowledged this was not representative. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month, but there was little meaningful data. The whole team was recently involved in reflection and discussion following an error. Team members had attended a meeting and discussed the importance of using near miss logs and recording meaningful reasons for errors. They had identified untidy shelves as a contributory factor in the recent error. The shelves were untidy at the time of inspection. Team members explained that they would like to tidy them, but they had not had time. And the pharmacy had recently passed an internal patient safety audit despite this. They had separated the items involved in the error. The pharmacy was completing weekly safer care audits, although the pharmacist explained it was challenging to undertake these regularly and thoroughly.

The pharmacy had a complaints procedure and welcomed feedback. The only example discussed was the dispensing error and the pharmacy had made changes noted above but not spoken to the person.

The pharmacy had an indemnity insurance certificate, expiring 30 April 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log, but some pharmacists did not complete this; private prescription records including records of emergency supplies and veterinary prescriptions, but some records were incomplete; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. 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 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 and they knew how to raise a concern. The pharmacy had a chaperone policy in place. The pharmacist was PVG registered.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy does not always have enough staff to provide safe services. It provides time at work and training material for team members to keep their knowledge and skills up-to-date. Team members can share information and know how to raise concerns to keep the pharmacy safe. They discuss incidents to learn from them and avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: two part-time pharmacists, one worked two days per week and one Saturday per month, and the other worked three days per week and one Saturday per month, and relief pharmacists worked two Saturdays per month; two full-time dispensers; one part-time dispenser; one full-time manager who was a dispenser; one part-time (one day per week) accuracy checking technician (ACT), one part-time medicines counter assistants (mornings), two Saturday only team members, one was new and not yet trained and the other was a pharmacy student; and a part-time delivery driver. One of the full-time dispensers was currently absent and was leaving the business at the end of the current week. And a part-time medicines counter assistant had recently left. The pharmacy was recruiting to replace them. The pharmacists had previously had a day per fortnight when they both worked and undertook tasks such as manging ‘owings’, chronic medication service (CMS) prescriptions, dealing with queries including ‘out-of-stock’ problems and multi-compartmental compliance packs. Team members explained that this had helped to prevent ‘back-logs’. The current staffing level was less than it was at the previous inspection a year ago. There was currently a part-time medicines counter, dispenser and the pharmacist double cover day less. And a year ago the team had described the workload as challenging as staff hours had decreased. The current team members demonstrated that they were ‘just managing’ and all tasks were being undertaken. But, there was little attention to detail including untidy medicines storage drawers; untidy fridges e.g. three different types of insulin (a high-risk medicine) stacked together, and other items placed in a way that the medicine name was not visible; minimal near miss recording as noted above, and not having time to obtain replacement prescriptions for incorrectly written ones. Team members partially attributed a recent dispensing error to staffing issues as there was absence at the time of the error. At the time of this inspection, the pharmacy had borrowed team members from other branches and they were able to manage the workload.

The pharmacy provided protected learning time for all team members to undertake regular training such as ‘my-learn’ modules, although not all team members had completed the current one (this was the last day of the month).

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 said they could make suggestions and raise concerns to the manager or area manager, but this was not explored further. The pharmacy superintendent shared information and

incidents from elsewhere in the organisation for all team members to learn from incidents. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. The manager who was not present manged these.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, and suitable for the pharmacy’s services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels (except the toilet which had no towels). The pharmacy stored bags of confidential waste in the toilet cubicle. The staff area was cluttered and untidy, but this did not impact people other than pharmacy team members.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and computer which was clean and tidy, and the door closed providing privacy. Temperature and lighting were comfortable.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy helped people to ensure they could all use its services. Team members give people information to help people use their medicines safely. The pharmacy gets medicines from reliable sources and mostly stores them appropriately. The pharmacy team knows what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a ramp at the entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. It could provide large print labels. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people’s medicines and prescriptions. The pharmacy had two dispensing work areas, one for ‘walk-in’ and one for collection service prescriptions. One team member usually worked in each area. At the time of inspection two dispensers were working on collection service prescriptions, with one labelling and the other dispensing. A team member was observed to pour tablets from a bottle directly onto the dispensing bench and use her hands to count them and re-pack. Team members sometimes shared relevant information with pharmacists such as the date of last dispensing, especially if they deemed medicines to be high-risk. The pharmacy did not follow a defined process for this. The team member had not highlighted a supply being made a fortnight after a month’s supply for a person recently. One of these supplies was an error. It is not known if intervention would have avoided or identified it. Team members 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. Some people received medicines from chronic medication service (CMS) serial prescriptions. One of the pharmacists had taken over the management of these around four months previously. She was in the process of updating electronic records to track prescriptions. The pharmacy dispensed these the week before expected supply to ensure they were ready for people. The team left these dispensed medicines on retrieval shelves for up to two weeks after their expected supply date. Then they removed them and contacted people by post to remind them. Most people were compliant, and this happened very infrequently. The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. One team member mostly did this, but others could deputise. An accuracy checking technician (ACT) from another branch came one day a week to check these. A pharmacist clinically checked the prescriptions the same day to enable her to carry out the accuracy check. Team members left stock packets to facilitate this check. They supplied patient information leaflets (PILs) to people monthly. They included some tablet descriptions on backing sheets e.g. one tablet out of 12 on one pack had descriptions. This had been discussed as an area for improvement at the previous inspection a year ago. The pharmacy stored completed packs in named boxes on dedicated shelves. The

pharmacy sent some prescriptions to an off-site hub for assembly of compliance packs.

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. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, supply of chloramphenicol ophthalmic products and chlamydia treatment. It also had private PGDs for flu vaccination. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under a 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.

All team members were trained to measure blood pressure and test for diabetes. But they were seldom required to do these. The pharmacists delivered the smoking cessation service, and this was currently not in great demand.

The pharmacy obtained medicines from licensed wholesalers such as alliance and AAH. It was not yet compliant with the requirements of the Falsified Medicines Directive (FMD). It had the equipment. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in three fridges with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. The two stock fridges were untidy; three different types of insulin were stacked together in one; and packs were placed in different orientations in the other making it difficult to identify items. 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 MHRA recalls and 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 for the delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts 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 the pharmacy had recently received (dated with first use) and a diabetes testing meter. Team members present did not know if this was regularly calibrated and no records were observed. They seldom tested people for diabetes. The team kept crown stamped and ISO marked measures by the sink in the dispensary and used separate marked ones for methadone. The pharmacy had a 'methameasure' pump available for methadone use and this was cleaned at the end of each day and test volumes poured each morning when it was set 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 inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

What do the summary findings for each principle mean?

✔ **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.