General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Unit 33; The Loan, SOUTH QUEENSFERRY, West Lothian, EH30 9SD

Pharmacy reference: 1085520

Type of pharmacy: Community

Date of inspection: 23/02/2022

Pharmacy context

This is a community pharmacy close to a GP practice in the town of South Queensferry close to Edinburgh. It dispenses NHS prescriptions, and offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. And it sells a range of over-the-counter medicines. The pharmacist advises on minor ailments and medicines' use, and supplies medicines on the NHS Pharmacy First service. 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 the risks associated with its services. Team members do not follow the standard operating procedures as this is not part of their induction. This means they have gaps in their knowledge which increases the risks in their ways of working. And this is seen in the way they deliver the pharmacy's services.
		1.2	Standard not met	The pharmacy does not monitor and review the safety and quality of its services. The pharmacy does not have arrangements in place to learn when things go wrong. It does not review dispensing errors and near miss errors so the team are missing learning opportunities.
		1.4	Standard not met	The pharmacy does not make sustained improvements to the safety and quality of its services following feedback from external stakeholders. It does not evidence any learning from this feedback.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough suitably trained and skilled team members to deliver all its services safely and effectively.
		2.2	Standard not met	The pharmacy does not support its inexperienced team members enough with training. So they do not have the skills, competence, or qualifications for their roles and the tasks they carry out.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	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 dispensing certain types of prescriptions.
		4.3	Standard not met	The pharmacy does not store and manage all its medicines safely due to poor stock

Principle	Principle finding	Exception standard reference	Notable practice	Why
				control. This includes inappropriate storage of excess stock of returned medicines. And a lack of segregation of usable and obsolete stock in some areas. The pharmacy does not have a robust date checking process and it has out-of-date medicines on its shelves.
		4.4	Standard not met	The pharmacy does not have evidence that it deals with medicine recalls appropriately. And the team does not know what to do. So, people may receive medicines that are not fit for purpose.
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. It does not ensure that team members follow written procedures for its services, so there is a risk of mistakes. Team members do not know to record and review their mistakes so cannot identify learning points. The pharmacy does not take appropriate action following feedback from external stakeholders which means it is missing opportunities to improve its services. The pharmacy keeps most records as it should by law, and it keeps people's private information safe.

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 hand sanitiser available. The pharmacy had standard operating procedures (SOPs), but most team members had not read them. Senior team members were not familiar with them so were not able to support colleagues reading, understanding, and learning from the SOPs. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. But team members had not read it. A 'one call menu' was on the wall, so they knew who to call for any maintenance issues.

Team members did not routinely record mistakes. The pharmacy had a 'near miss log' to record dispensing errors that were identified in the pharmacy, known as near miss errors. But team members were not familiar with it. The pharmacy had last used it several months ago, and there was no evidence of reviewing mistakes to learn from them. The pharmacy was not undertaking other reviews or audits such as the Lloyds Safer Care audits. No records or improvements were observed for known incidents recently highlighted to the GPhC. The manager was reviewing the use of space on the premises. He had made an impact clearing obsolete items and rubbish and improving some storage, but this was not complete. The pharmacy had received negative feedback from a variety of individuals and organisations over the past few months. This had included people contacting the NHS and posting on social media. But there was no evidence of sustained improvements in services and recently concerns had been raised with the GPhC.

The pharmacy had indemnity insurance, expiring 30 June 2022. The pharmacy displayed the responsible pharmacist notice and kept a responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It had kept unlicensed specials records previously but there were no recent records. And it kept controlled drugs (CD) registers with running balances maintained but not regularly audited. And most team members were not aware of the CD destruction register for patient returned medicines, and it could not be found.

Pharmacy team members were aware of the need for confidentiality. But they had not undertaken any training or read a SOP. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had not been trained on safeguarding. But when posed with a scenario they explained that they would speak to the pharmacist if they had concerns. The pharmacist knew that processes and contact details for the health board area were on the NHS Community Pharmacy website.

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

Summary findings

The pharmacy does not have enough competent or experienced team members to provide all its services safely and effectively. And it does not provide time, support, or resources for team members to learn. Team members work hard to provide the pharmacy's services and improve standards. But do not have all the skills they need to succeed.

Inspector's evidence

The pharmacy had suffered with staffing issues over the past few months. The pharmacist who had worked in the pharmacy for several years left in August 2021 (six months ago) and had not been replaced. A variety of locum pharmacists had been working since then. And most team members had left in October 2021 (four months ago). The pharmacy had been recruiting team members since then. It now had a full-time non-pharmacist manager who had started this role in November 21 (three months ago), three part-time dispensers working 16, 12 and four hours per week respectively, and three trainee team members who had started their role within the last two months. Another new trainee team member had left within a few weeks. The manager and trainee team members had no previous experience of pharmacy. The locum pharmacist present at the time of inspection was working in the pharmacy for two weeks which was providing some continuity. He had not worked in this pharmacy before. The manager, a part-time dispenser and three trainee team members were working at the time of the inspection. The pharmacy had not provided the trainees with any induction training and had recently registered them on appropriate accredited courses. But they did not have time at work to undertake training, and there were no experienced team members to support and coach them. And there was no regular pharmacist to supervise their learning. Team members were not aware of any training support or virtual sessions that may be available. They did not know how to undertake some processes in the pharmacy including the management of serial prescriptions or managed repeat prescriptions. And they did not know how to deal with medicines' recalls and ordering of 'specials'. The locum pharmacist was supporting team members as much as he could, and they were observed to ask him questions about prescriptions. Sometimes the pharmacy had a second pharmacist one day per week, and they undertook tasks such as CD running balance checks and dealing with uncollected dispensed medicines. Team members were polite to people and tried to help them within their competence.

The team did not record or discuss incidents and mistakes. So, team members did not learn from each other or from their own mistakes. The manager described sharing concerns about the lack of skills and experience in the team with the area manager. But the area manager had only been in the role since the middle of January (one month), was new to the company and had no pharmacy experience. So, she was limited in the support she could offer. There had been a variety of area managers for short periods of time over the past few months which had been challenging for the team. The company had a whistleblowing policy dated 2015 in the staff kitchen. Not all team members had read it. The company set targets for various parameters but meeting these was not currently a priority as the processes in the pharmacy were not embedded.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the pharmacy services provided. The pharmacy has appropriate facilities for people to have conversations with team members in private. But the team does not use some staff facilities and storage areas due to poor maintenance and clutter.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary, a storeroom, and basic team facilities. There were two toilets used by male and female team members. Both cubicles had damp walls that required attention. One was particularly bad and team members avoided using it when possible. The team had reported this but did not expect work to be carried out for several weeks. The pharmacy had a disabled toilet, but the team could not use it as it was piled high with dispensed medicines that had not been supplied to people. The premises were basically clean but there was large amount of rubbish to be disposed of and clutter to sort through. 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 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 and the door closed providing privacy. Temperature and lighting felt comfortable throughout the premises.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy helps people to access its services. But it does not always manage and deliver all its services safely and effectively. And its team members are not always competent to deliver them. The pharmacy obtains medicines from reliable sources but it does not store and manage all medicines properly. And team members do not all know what to do if medicines are not fit for purpose. 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 a power assisted door. And team members assisted people when required. The pharmacy had leaflets available on a variety of topics. And it provided a delivery service.

A team member collected prescriptions from the near-by surgery twice a day and scanned them onto the electronic system which enabled team members to confirm if prescriptions were in the pharmacy. And a team member filed them alphabetically. Team members usually dispensed prescriptions when people asked for them at the pharmacy. This resulted in people's expectations not being met, leading to complaints and increasing pressure on team members. Previously they had dispensed them in advance, but this system had not worked effectively, and sometimes there were multiple prescriptions for the same person. This resulted in a lot of dispensed medicines not being collected. And there was considerable workload for team members to deal with uncollected dispensed items. This situation had come about because team members had not been trained in the processes for managing and dispensing different prescription types including serial prescriptions, managed repeat prescriptions, and prescriptions assembled at an off-site hub. When dispensing, pharmacy team members followed a methodical workflow. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. But team members who were labelling and dispensing did not check the patient medication record for date of last supply, new items or changes to medication. This was attributed to their lack of knowledge and inexperience, and they had not received any training. And it was therefore difficult for the pharmacist to carry out an effective clinical assessment. Most team members had started in the pharmacy recently and had not received any structured training. They knew how to generate labels, select medicines, and attach labels to the medicines. But, for example, they did not know to check expiry dates of medicines as they dispensed. 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, but currently there were delays related to ineffective ordering and stock management. The pharmacy sent some prescriptions electronically to an offsite hub to be dispensed. But most team members were not trained in this process, meaning that fewer than expected were managed in this way which increased the workload in the pharmacy. And the process was not working. There were a lot of uncollected items from a few months ago that had been dispensed at the hub. Several were observed dated November 2021.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. But team members did not know how to process these prescriptions, so there was a risk of people receiving incorrect medicines. And there was an example of a person continuing to receive medication after the

prescriber had stopped it. There were examples of people coming to the pharmacy to collect their medicines and there was none for them and no prescription on the premises. This was seen to be due to team members incorrectly sending prescriptions for processing, due to their lack of knowledge of the process. A team member who no longer worked in the pharmacy had previously managed this service. Due to the lack of consistent pharmacist, and team members not trained, the pharmacy was not following the service specification for serial prescriptions as it was not carrying out pharmaceutical care needs' assessments within three months of registration, as required by the service specification.

The pharmacy supplied a variety of medicines by instalment. A trained 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. They were stored in individual baskets on dedicated shelves in a room behind the dispensary.

A pharmacist undertook clinical checks although this was sometimes difficult as team members did not know what relevant information to share from the patient medication record (PMR). They provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. Team members were not all aware of the valproate pregnancy prevention programme. The locum pharmacist had completed appropriate training for medicines supplied by pharmacists under patient group directions (PGDs). But he had not signed the PGDs in this health board area. He explained how he would do this before making any supplies in this way to ensure he supplied medicines appropriately, safely, and legally. Pharmacists delivered the smoking cessation service when there was demand for it, but this was not consistent due to the number of locum pharmacists working. Other team members were not trained and competent yet to do this.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored medicines mostly in original packaging on shelves, in drawers and in cupboards. Some drawers were over-filled, and different products were stored together, for example two strengths of tramadol stored together, and trospium and valsartan stored together. This posed a risk of the wrong product being selected and supplied. There were some tablets in bottles with incomplete labelling, and team members did not know how long they had been out of the manufacturers' packaging. So, these tablets may not be fit for purpose. Team members segregated and labelled some obsolete items well, including some patient returned medicines and some out-of-date medicines. But in other areas, such as a stock room, they did not clearly label and segregate obsolete and useable medicines. Part of the issue was a large over-stock of some items. Meanwhile there was no stock of some commonly use medicines including atenolol and loratadine tablets. This was attributed to team members not undertaking company systems such as regular stock checks. They had not been trained to do this. And sometimes locum pharmacists over-ordered items to ensure there was sufficient stock for prescriptions. 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 did not undertake regular date checking. And they did not rotate stock. Some items inspected were out of date and some were short dated, meaning they could be out of date before a person had completed the prescribed course. The pharmacy protected pharmacy (P) medicines from self-selection. Team members had not received training on the sale of medicines protocol, so referred most requests to the pharmacist. The pharmacy did not follow the SOP for removing dispensed items from retrieval shelves and contacting people who had not collected their medicines. Team members had not read the SOP or been trained in this process. This contributed to a large volume of uncollected medicines which filled the disabled toilet making it unusable. And many were contained in totes in a storage area.

The pharmacy did not have evidence of acting when it received Medicines and Healthcare products

Regulatory Agency (MHRA) recalls and safety alerts. Team members did not know about these. The last one observed was dated June 2020. 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 it looks 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 had equipment it required to deliver pharmacy services. This included a carbon monoxide monitor maintained by the health board, and a blood pressure meter which was replaced as per the manufacturer's guidance. The team was not using this equipment during the pandemic to reduce the chance of spreading infection. And team members were not trained to deliver these services. It had ISO marked and crown-stamped measures, and separate marked ones were used for methadone. And it had clean tablet and capsule counters.

The pharmacy stored paper records in the dispensary and office 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.