General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Bathgate Primary Care Centre, Whitburn Road, BATHGATE, EH48 2SS

Pharmacy reference: 1086198

Type of pharmacy: Community

Date of inspection: 23/11/2022

Pharmacy context

This is a health centre pharmacy on the outskirts of Bathgate town centre. In addition to dispensing prescriptions and selling over-the-counter medicines, the pharmacy supplies medicines for its substance misuse service. And it provides medicines under the NHS Pharmacy First service. The pharmacy also provides some prescription medicines under Patient Group Direction (PGD).

Overall inspection outcome

✔ **Standards 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 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 has written procedures to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's private information properly. The pharmacy adequately identifies and manages the risks associated with its services. And team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy had felt the pressures of a heavier workload during and since the pandemic. It had experienced a reduction in team members working alongside an increase in prescription numbers. And so, it had reduced its range of services so that it could concentrate on delivering a safe prescription service. It had kept several of its patient group direction (PGD) based services. The pharmacy did this so it could treat a greater range of conditions more effectively. And so, it supplied the appropriate prescription medicine for a select range of conditions without people having to go to their GP.

The team had a system for recording its mistakes. It recorded them electronically. And it reviewed them monthly in its patient safety review meetings. The pharmacist was a locum. And this was the first time she had worked at this pharmacy. But she described how, as part of her day-to-day practise, she highlighted and discussed 'near misses' and errors as soon as possible with the team member involved. She did this to help prevent a similar mistake in future. But the pharmacy's near miss records did not contain much detail. The inspector and pharmacy manager discussed the importance of recording what the team had learned from its mistakes and any actions arising from them. They discussed how this would provide more information for the review meetings. And so, help the team to learn and continually improve. They agreed that near miss mistakes should prompt staff to identify what they could do differently to help them avoid making a similar mistake again. But although the team had not kept full records it was clear that the team had taken some steps to reduce the risk of repeating them. Team members described how they had separated medicines which looked alike and names sounded alike (LASA) to reduce the chance of selecting the wrong one. The team demonstrated how it had separated stocks of medicines with names beginning with the letter A. These included amitriptyline, amlodipine and allopurinol. And it had done the same with other similar products.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) to follow. The SOPs were available electronically on the intranet system which team members could access on any available computer in the pharmacy. Team members had read the SOPs relevant to their roles. And new trainee staff had begun to read them. The trainee healthcare partner (HCP) was observed reading SOPs during the inspection. Team members appeared to understand their roles and responsibilities and consulted the pharmacist when they needed her advice and expertise. The RP had placed her RP notice on display where it could be seen by people. The notice showed her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. People gave feedback directly to team members. And, if necessary, the pharmacy team provided details of where people should register a complaint. It also provided information on the local health board's complaints procedure which the

team could obtain online. But while customer feedback was usually positive the pharmacy had received comments from people who were concerned about waiting times and medicines availability. And the pharmacy's unplanned closures. But while the pharmacy still had issues with a backlog of work affecting waiting times, the temporary pharmacy manager had engaged extra help from other Lloyds pharmacy teams when she could. And she had recruited a part-time trainee HCP. And while medicines shortages were largely outside of the pharmacy's control, the team had tried to help people affected. It signposted them to other pharmacies. And it contacted their GPs to suggest alternatives when their medicines were not available. One suggestion the team had made was to substitute one strength of a medicine with another. This meant that with proper counselling people did not go without the appropriate treatment. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its unlicensed specials records, private prescription records, RP records and controlled drugs (CD) registers. And while it had not been able to conduct its usual weekly checks, it maintained and audited its CD running balances when it could. And during the inspection, a check of a product in stock matched the running balance in the pharmacy's CD register. The pharmacy kept a CD destruction register for patient returned CD medicines. But the register was not fully up to date. The pharmacy also had the appropriate records for supplies made under the NHS Pharmacy First service, the NHS 'Medicines Care Review' (MCR) service and serial prescriptions. It did not have records for emergency supplies as it didn't make any. Instead, the pharmacy supplied emergency medicines by using the NHS Unscheduled Care patient group direction (PGD). And it recorded these supplies using the necessary form (UCF). And notified the patient's GP. The team knew that it was important to ensure that all the pharmacy's essential records were complete and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed appropriate training. Confidential paper waste was discarded into separate waste bags. And the bags were collected regularly by a licensed waste contractor for safe destruction. The pharmacy kept people's personal information, including their prescription details, out of public view. And it had a safeguarding policy. Team members had completed appropriate safeguarding training. And they had a good understanding of their safeguarding responsibilities. They reported any concerns to social services, the police or a person's GP as appropriate. The team accessed details for the relevant authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has put some measures in place to help ensure it manages its workload safely. And its team members support one another to do this. Team members are comfortable about providing feedback and they make suggestions to help improve the quality of the pharmacy's services. Team members have the right skills and training. But they sometimes struggle to manage the dispensing workload efficiently.

Inspector's evidence

The inspector conducted the inspection during the pharmacy's usual trading hours. The locum RP worked alongside the temporary pharmacy manager who was also a dispensing assistant (DA). The temporary pharmacy manager worked at the pharmacy from time-to time to support the team. But she had managerial and DA responsibilities at her own branch. And so, her time at the pharmacy did not replace that of the full-time pharmacy manager who had left. The pharmacy also had an HCP working in the dispensary. And it had an HCP and a trainee HCP working on the counter. The HCP role provided the team member with dispensing assistant training and medicines counter assistant training. And so, HCPs on the counter also helped in the dispensary when they could. Staff from other local branches had on occasions helped for short periods. But these branches reportedly could not help often due to their own staffing levels. As the pharmacy did not currently have a regular RP, locums provided pharmacist cover. The locums had a variety of different experience. But the locum during the inspection had worked at other branches of Lloyds pharmacy before. And so, she was familiar with the pharmacy's general procedures.

The pharmacy had closed on three occasions when it did not have enough staff. It had closed for half a day each time. And so most people could still get their medicines when the pharmacy opened again. Some people were able to get their medicines from other branches of Lloyds locally if they could not come back when the pharmacy was open. But others had taken their prescriptions elsewhere.

The pharmacy was extremely busy. And the team was behind with the daily workload of prescriptions. The temporary pharmacy manager felt this was due to the disruption caused by the sudden departure of the manager two weeks before. And the lack of a regular pharmacist, which led to problems with pharmacist cover and unplanned closures. The pharmacy had also had other staff absences. And while a new trainee HCP had been recruited, they were undergoing induction and training and required additional support. The team worked well together and worked hard to provide essential dispensing services. But they were working under pressure. Team members helped each other to complete their tasks when they could. In response to the backlog of work they had got together to devise a new system for managing repeat prescriptions and the overall workflow. They now produced the labels and ordered the stock for prescriptions as soon as possible after they received them. And then they filed them in alphabetical order. They did this so that they could assemble the prescriptions more quickly for people when they came in to collect them. This reduced the time that people otherwise had to wait. And it reduced the number of visits they had to make to the pharmacy.

Pharmacists could make day-to-day professional decisions in the interest of people and did not feel under pressure to meet business or professional targets. And team members could discuss their concerns with their line managers. They generally discussed issues as they worked. Staff described

feeling supported in their work by their colleagues and their managers. They generally had regular reviews about their work performance. And they kept their knowledge up to date through online training modules.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And it is sufficiently clean and secure. The pharmacy is generally organised. But it is cluttered and untidy in some areas.

Inspector's evidence

The pharmacy was in self-contained premises attached to the health centre. It had a shuttered doorway inside which people used to walk between the health centre and the pharmacy. And it had its own, external doorway which gave independent access from outside. The pharmacy had a retail space which was sufficient to stock its general sales medicines, beauty products and other items related to health and wellbeing. It kept its pharmacy medicines behind the medicines counter. And alongside the medicines counter it had a consultation room. People accessed the consultation room from the retail area.

The pharmacy had a spacious dispensary. It had a run of dispensing work surface on two sides with storage above and below. The work surfaces were connected in an 'L' shape. It also had a run of pull-out drawers where it stored most of its medicines. And it had a separate section with a sink for dispensary use. The team had organised the work surface to provide separate areas for dispensing repeat prescriptions and medicines care review (MCR) prescriptions. It dispensed its walk-in and acute prescriptions on the work surface next to the accuracy checking area, so that they could be dealt with promptly after dispensing. The team stored its completed prescriptions on wall space between the counter and the accuracy checking area in the dispensary. This made it easy for staff to get to from both areas.

The pharmacy had an additional room towards the rear of the premises. The room had several uses. It was used as a staff area, an office area and for storage. The team cleaned the pharmacy periodically. And stock on shelves was generally tidy and organised. But work surfaces were cluttered. And, in some areas of the dispensary floors were cluttered with bulky stock items, dispensing baskets and tote boxes. And floors had dust and debris round the edges. The inspector and team members agreed that it was important to maintain a clean and organised dispensing environment. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. And it supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members generally make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally stores its medicines as it should.

Inspector's evidence

The pharmacy promoted its services and its opening times on its windows and doors. It had step-free access and double automatic doors at its external entrance. And inside, its doorway provided free flowing access between the pharmacy and the health centre. The team kept the retail area free of clutter and unnecessary obstacles. And it had a low counter suitable for people who may have difficulty using the main counter. The pharmacy had a delivery service for people who could not visit the pharmacy to collect their prescriptions. And it could also order people's repeat prescriptions for them. Recently, the pharmacy had closed on three separate half-days and on these days it had put notices up on its doors to tell people where they could get their medicines. The pharmacy team had followed its contingency plan. And it had informed its neighbouring pharmacies, substance misuse clinics and local GP practices of the closures in advance. It had ensured that nearby branches of Lloyds had either access to prescriptions where appropriate or could provide medicines through the Unscheduled Care service. This was so that people could get a supply of their essential medicines, including their medicines for the substance misuse service. When the pharmacy opened again the team accessed people's Emergency Care Summary to see if they had picked up a supply of their medicines elsewhere. The pharmacy could then make the appropriate adjustments to remaining supplies.

The pharmacy team used baskets to hold individual prescriptions and medicines together during dispensing to help avoid errors. It did not provide medicines in multi-compartment compliance packs for people. This service was provided from other local branches of Lloyds which had the capacity and resources to manage it. The RP gave people advice on a range of matters. And she explained how she gave appropriate advice to anyone taking higher-risk medicines. The pharmacy had a small number of people taking sodium valproate medicines. This didn't include people in the at-risk group. The RP described how she counselled at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacy also knew to supply the appropriate patient cards and information leaflets each time.

The pharmacy offered the NHS Scotland 'Pharmacy First' service. Where people could obtain medicines for a range of minor ailments and conditions. Several team members had been trained to supply medicines for a small range of conditions. And they followed the local health board protocol by supplying medicines from a specified list. The list included medicines such as ibuprofen and paracetamol. And treatments for coughs and colds. Team members referred to the pharmacist when someone presented with a condition which they had not been trained to treat such as a urinary tract infection (UTI). The pharmacy supplied a selection of items under PGD. Besides medicines for UTIs it supplied medicines for impetigo, gluten free products and emergency hormonal contraception.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The team

knew how to process serial prescriptions. And it had a system for monitoring and tracking supplies so that it knew when people were due to get their medicines. The system also allowed the team to monitor compliance and address any issues. The team used the pharmacy care record to identify people for review. These were often people on regular repeat prescriptions. It used the NHS medicines care review (MCR) process to identify any care issues, referring people back to their GP where further medical intervention was required. The pharmacy supplied a variety of medicines by instalment. The pharmacist checked the instalments and placed the labelled medicines together in individual baskets to keep the instalments together.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines, appropriately. And stock on the shelves was tidy and organised. Until the previous month, the pharmacy date-checked its stocks regularly. And it kept records to help the team manage the process effectively. But the inspector found a pack of Hypovase 1mg tablets which had expired at the end of the last month. The team described how it conducted an expiry date check as part of its dispensing process. They did this to ensure that any out-of-date medicines could be detected as they were dispensed. In general, short-dated stock was identified and highlighted. And the team put its out-of-date and patient returned medicines into dedicated waste containers. The team stored fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean and well maintained. The team uses its facilities and equipment to keep people's private information safe

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. It had an automated measuring device for measuring methadone liquid. The device recorded each dispensing electronically. The team cleaned and calibrated the measure each day. They did this to make sure it was hygienically clean and accurate. Team members had access to a range of up-to-date reference sources, including access to the internet to provide it with up-to-date clinical information. The team had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves if they needed them. The pharmacy had several computer terminals which had been placed in the consultation room and the dispensary. Computers were password protected to prevent unauthorised access. The pharmacy had cordless telephones to enable the team to hold private conversations with people.

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.