General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, The Health Centre Site, 146 Dalmellington Road, AYR, Ayrshire, KA7 3PR

Pharmacy reference: 1097483

Type of pharmacy: Community

Date of inspection: 23/06/2022

Pharmacy context

This community pharmacy is in a medical centre in Ayr. The pharmacy's main services are dispensing NHS prescriptions and delivering medicines for some people to their homes. The pharmacy supplies several people with their medicines in multi-compartment compliance packs to help them take their medicines. The pharmacy offers the NHS Medicines Care and Review (MCR) service.

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 team is working under significant pressure over long hours to manage the workload and at the same time acquire new skills to use the updated computer system. This substantially impacts on the team member's capacity to provide efficient pharmacy services and increases the risk of them making mistakes.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's dispensing area is excessively cluttered with limited space to work. And the team stores several large boxes and bags containing medicines on the floor in the small dispensary. This presents a significant risk to safe delivery of pharmacy services and to the team's safety.
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 has up-to-date written procedures that the pharmacy team follows. And it completes all the records it needs to by law. The pharmacy protects people's private information properly. The pharmacy team members respond suitably when errors occur. They generally discuss what happened and they take appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). All team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions. For example, when the pharmacist spotted an error when completing their check of the dispensed prescription. The pharmacy team usually kept records of these errors known as near misses but no entries had been made since 01 June 2022. The team members mostly recorded the cause of the near miss error, their learning from the error and the actions they had taken to prevent the error happening again. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. The procedure included the team completing an electronic dispensing incident report to send to head office. The team members were not always informed of the dispensing incident to ensure they were aware it had happened and could learn from it. The team had introduced an additional step to the processing of prescriptions containing controlled drugs (CDs) following a recent incident when a person was supplied their CD medication for two weeks when the prescription called for one week. This additional step involved the team members asking the pharmacist to complete a second check of the prescription and the dispensed CD before it was handed to the person. This was observed during the inspection.

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 and dispensing incidents. The team kept notes from the briefings that detailed the discussions held and who in the team had attended. A recent briefing discussed the importance of taking time when dispensing and to always refer to the prescription. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And a leaflet provided people with information on how to raise a concern with the pharmacy team.

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 balance of CDs was regularly checked to spot errors such as missed entries. A random check of the balance of a CD found it was correct. The team members had completed training about the General Data Protection Regulations (GDPR). And they 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. The delivery driver reported concerns about people they delivered to back to the team who took appropriate action such as contacting the person's GP.

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

Summary findings

The pharmacy team is working under significant pressure over long hours to manage the workload and at the same time acquire new skills to use the updated computer system. The pharmacy is behind with some routine tasks. And some people cannot collect their medicines when they choose to. This increases the risk of the team making mistakes. Team member complete some training when they can. And they receive some feedback on their performance.

Inspector's evidence

The pharmacy was supported by locum pharmacists following the recent departure of the regular pharmacist. Most of the locum pharmacists had not previously worked at the pharmacy. This meant they were not familiar with the pharmacy's system and workload. The pharmacy team consisted of experienced team members and new team members. The full-time pharmacy manager was an accuracy checking technician (ACT) and was supported by three part-time qualified dispensers, a part-time medicines counter assistant, two new team members and a delivery driver. At the time of the inspection a locum pharmacist, the pharmacy manager, three dispensers, a locum dispenser and a medicines counter assistant were on duty. The team members on duty at the time of the inspection worked well together and supported each other. But they worked under pressure and had a backlog of work.

Over the course of the COVID-19 pandemic some team members had been off work and at the time of the inspection two team members were not available for work. The pharmacy had undergone a reduction in staff hours which resulted in times of the day when there was only one team member on duty with the pharmacist. And on occasions especially over the weekend the pharmacist was on duty with only a trainee member of the team. This had led to queues of people waiting to be served, delays with the processing of prescriptions and tasks such as date checking not being completed. The pharmacy had recently completed a planned upgrade of its IT system. The team members had completed internal online training modules regarding the upgrade. And were advised that a company trainer would attend the pharmacy to provide practical training and support for the team once the system was installed, this had not happened. The only practical training the team received was from the colleague present on the day the IT upgrade was installed. And some limited training and support from a colleague based at a Lloyds Pharmacy nearby who was familiar with IT upgrade. The team members were slowly learning to use the system and using work-around methods to complete tasks. This had led to a backlog of prescriptions waiting to be dispensed.

The pharmacy manager regularly contacted the area manager, who was not based locally, to voice concerns about the impact the reduced hours and IT upgrade were having on the team's workload and the pressure the team members were under. Locum pharmacists had contacted the area manager to raise similar concerns. The area manager responded via email and phone call but had only attended the pharmacy once for a short period of time. The area manager had arranged with the Health Board for the pharmacy to open to the public for a limited time between Monday and Friday to help the team catch-up with the processing of prescriptions. The pharmacy manager reported the team had moved from being five days behind with the processing of prescriptions to two days. The pharmacy manager was discussing with the area manager a plan to permanently reduce the opening hours. The pharmacy manager explained this would enable a rota of daily tasks to be allocated to all the team as there would

be more team members on duty at the same time. This meant that key tasks such as date checking stock and cleaning would be completed. The ACT explained she had limited opportunities to accuracy check prescriptions as she was helping the team with the dispensing of prescriptions. And was concerned she may not meet the required number of accuracy checks needed to maintain her skills.

Experienced team members reported increased workplace pressures since the team numbers had reduced. The pharmacy manager had contacted the local GP teams asking them to inform people to allow at least 48 hours from the prescription being released to collection from the pharmacy. Some GP teams had supported this request but others had not which resulted in several people presenting at the pharmacy expecting their prescription to be ready. Team members were regularly subjected to aggressive behaviour directed towards them from people when there were delays to the supply of their medication. Team members were upset when describing to the inspector the increased workload pressure and anger directed towards them.

The team members used company online training modules to keep their knowledge up to date. The team members were previously given protected time to complete the training but recently team members had completed the training at home. The pharmacy manager was part of a social media group for managers where different information and support was provided. The pharmacy occasionally provided performance reviews for the team. This gave team members a chance to receive individual feedback and discuss their development needs.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is clean and secure. But excessive clutter presents a significant risk of mistakes. The team dispenses medicines in a small and restricted workspace. And the pharmacy stores several large boxes containing medicines on the floor in the small dispensary which creates a significant risk to the team's safety. The pharmacy has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy premises were hygienic and secure. The pharmacy had restricted access to the dispensary during the opening hours. It had separate sinks for the preparation of medicines and hand washing. The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had a large, soundproof consultation room. The team used this for private conversations with people and offered the room as a private space for people receiving supervised doses of their medication.

The dispensing benches were cluttered with baskets piled on top of each other, creating an increased risk of errors. Several tote boxes containing medicines delivered by the wholesalers were stored on top of each and covered most of the floor space in the dispensary. The team stored some completed prescriptions in large carrier bags on the floor of the dispensary. The dispensary was small with limited space to work and move around. The tote boxes and bags of prescriptions further reduced the space available for the team to safely move around. And significantly increased the risk of trip hazards. The space available for preparing the compliance packs was small. This limited the number of packs that could be prepared at any time and contributed to limited timescale for preparing the packs.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that generally support people's health needs. The pharmacy team manages its services adequately. The team members keep records of deliveries the pharmacy makes to people. So, they can usually deal with any queries effectively. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages medicines appropriately.

Inspector's evidence

The pharmacy had recently reduced its daily opening hours between Monday and Friday, its weekend hours remained the same. This was a temporary measure to help the team manage its increased workload. And was agreed with the NHS. The new hours were clearly advertised on the front door and windows of the pharmacy. The reduced hours created a queue of people outside the pharmacy before it opened and this continued, along with a queue of people in the pharmacy, throughout the opening hours. During the inspection several people presented at the pharmacy to collect prescriptions that were not ready. The team had discovered some GP teams were advising people their prescription would be available at the pharmacy when it had only just been sent from the GP. This information resulted in many people presenting at the pharmacy expecting their prescription when the team had only just received it. And often caused people to become aggressive towards the team. The team advised that several issues following the IT upgrade had led to delays with the dispensing of people's prescriptions. So, when people presented the team often had to dispense the prescription at that time, rather than in advance which increased the team's workload and pressure. And resulted in many people feeling angry and frustrated. The pharmacy team members ordered some people's prescriptions on their behalf but since the IT upgrade they hadn't been able to do so as they hadn't received training. The team apologised to people contacting the pharmacy requesting this service and signposted them to their GP. The team wore name badges detailing their role so people using the pharmacy knew who they were speaking to. The team asked appropriate questions of people when selling over-the-counter products and knew when to refer to the pharmacist.

The pharmacy provided multi-compartment compliance packs to help around 80 people take their medicines. The team usually prepared prescriptions one week before supply to allow time to deal with issues such as missing items and the dispensing of the medication into the packs. But as the team members were learning to use the upgraded IT system the processing time had generally reduced to the day of supply. The team members managing this service were aware of the risks associated with preparing the packs under pressure. And had raised concerns, through the pharmacy manager, with the area manager. The team member preparing the packs worked at a separate computer station in a small, dedicated area of the dispensary. Other team members knew to not disturb their colleague whilst they were undertaking this task. The pharmacy had been using Lloyds offsite dispensary for the dispensing of the compliance packs. Since the upgrade the team hadn't sent any packs to the offsite dispensary as they'd not received training on how to do this. Each person had a record listing their current medication and dose times. The team 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. Completed packs were stored on dedicated shelves in box files labelled with the person's name and address.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The

pharmacy prepared the doses using an electronic pump. The pump was linked to a laptop that the team updated with the doses on receipt of a new prescription. The pump was regularly cleaned and calibrated to ensure the correct amount of medication was supplied each time. The team provided people with clear advice on how to use their medicines. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had information to provide to people when required. The pharmacist and ACT kept a record of the conversations held with people prescribed high risk medicines for them to refer to when required at a later date.

The pharmacy provided limited space for the team to separate 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. But these baskets were piled on top of one another increasing the risk of mistakes. 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 both boxes. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge 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 kept a record of the delivery of medicines to people. At the time of the inspection the team was busy preparing prescriptions for delivery due out that day whilst the driver was waiting to leave the pharmacy.

The pharmacy obtained medication from several reputable sources. The pharmacy team occasionally checked the expiry dates on stock. The pharmacy had a document to record this activity but no records had been made this year. The team members usually marked medicines with a short expiry date to prompt them to check the medicine was still in date. Some medicines were found with expiry dates in September 2022 and November 2022 that hadn't been marked. A bottle of liquid medicine was found with expiry date of May 2022, this was not marked. The team checked the expiry dates as part of the dispensing and checking process. The dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day. A sample of these records found they were within the correct range. 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 CD cabinets that met legal requirements. 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 which included a range of CE equipment to accurately measure liquid medication. The pharmacy had a large fridge with a glass door that enabled the team to check the stock without prolong opening of the door. The fridge was full of stock and completed prescriptions waiting to be supplied. This meant the efficient flow of air around the fridge may be affected. The pharmacy computers were password protected and the team positioned the dispensary computers in a way to prevent disclosure of confidential information. 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.