General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 25 King Street, BATHGATE, West Lothian, EH48 1AZ

Pharmacy reference: 1108387

Type of pharmacy: Community

Date of inspection: 01/09/2021

Pharmacy context

This is a community pharmacy beside other shops and close to the town's railway station. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. This pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 now identifies and addresses the risks with its services. This includes reducing the infection risk during the pandemic. The pharmacy team members now mostly follow written processes for the pharmacy's services to help ensure they provide them safely. The pharmacy reviews processes and makes improvements to improve safety. Team members record some but not all mistakes to learn from them. They could be missing opportunities to make improvements by not recording them all. The pharmacy keeps the records that it needs to, but some are incomplete.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. This included screens at the medicines' counter, and markers on the floor to encourage people to socially distance. It allowed four or five people on the premises at any time if they were socially distancing. Team members managed this when they could. People were observed queuing outside during the inspection. Most people coming to the pharmacy wore face coverings and team members all wore masks. They also washed and sanitised their hands regularly and frequently. Team members were not aware of personal risk assessments being carried out. Some were carrying out regular lateral flow Covid tests. This had not been discussed with newly recruited team members.

The pharmacy had standard operating procedures (SOPs) which were now being followed. There had been a period of a few months when the team did not follow them. The pharmacy had been short-staffed and had no regular pharmacist. SOPs that team members had not followed included management of controlled drugs and management of multi-compartment compliance packs, which had led to mistakes being made. New team members were in the process of reading the SOPs. Experienced 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 individual record cards confirmed which SOP each team member had read. Some team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They had recent experience of this as there had been days when there was no pharmacist available. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. And head office had issued guidance to be followed when there was no pharmacist. This included informing stakeholders and listing activities that could not be undertaken.

Team members sometimes used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. But they were not doing this all the time, so there was limited data to review and learn from. And they recorded errors that had been identified after people received their medicines. The SOPs required that the team reviewed all near misses and errors each month to learn from them and they introduce strategies to minimise the chances of the same error happening again. But due to staff shortages and inexperience this had not been done routinely over the past few months. The area manager was in the process of re-establishing this and all team members had been reminded to record all errors and incidents. The area manager along with the team had recently reviewed all processes in the pharmacy, identifying several that were not as per the SOPs or being managed safely. An action plan had been developed and the team was in the process of working through this to improve safety in the pharmacy. This had resulted in some processes being completely

changed to improve efficiency and safety. This included routine dispensing of repeat prescriptions, management of multi-compartment compliance packs and controlled drug management. The company 'safer care' monthly programme included weekly audits and self-assessments on four themes, so each was audited monthly. These had been re-introduced recently and had highlighted several issues e.g. new dispensing equipment was required which had been obtained and was in use. The area manager was updating the action plan as actions were completed. The divisional quality manager agreed to share regular updates with the inspector.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2022. The pharmacy displayed the responsible pharmacist notice and had a responsible pharmacist (RP) log. This showed several days over the past month when there had not been a responsible pharmacist for whole or part days. Some days had no entry which either meant that the pharmacist had not made an entry or there had been no pharmacist e.g. 3rd, 10th and 30th August. There were also some inaccuracies e.g. a pharmacist signed in until 8pm when the pharmacy closed, and the team left at 6pm. And pharmacists remaining signed in until the following day. This was not always clear from the RP log; it showed that the pharmacist was signed in for e.g. two minutes rather than 24 hours and two minutes. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. But these were in a book labelled 'Phoned-in prescriptions'. Many records had lines through them suggesting that they had been 'phoned-in' (emergency supplies at the request of the prescriber), and prescriptions subsequently received. But private prescriptions corresponding to some of these records were observed. This was not an appropriate way of recording emergency supplies, which must include the wording 'Emergency supply'. The pharmacy kept some unlicensed specials records, but these were incomplete and filed in at least two different places. And controlled drugs (CD) registers were in place with running balances maintained and now regularly audited. There had been a period of poor record keeping with registers not kept up to date and running balances not regularly audited. This had resulted in several running balance discrepancies. Over the past few weeks these had been investigated by different pharmacists, area managers, a loss prevention officer and the divisional quality manager. Some had been resolved; there had been a variety of errors and omissions causing them. But a few remained unresolved despite the time spent on them. The pharmacy was preparing a final report for the NHS CD accountable officer who was aware of the issues. The CD registers were observed to now be filed neatly and logically with foot notes explaining the results of investigations. All running balances were now correct. No-one in the pharmacy at the time of the inspection knew where the patient-returned controlled drug destruction register was. Locating this was a priority and was included in the internal action plan. 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 and/or covered this during training. They segregated confidential waste for secure destruction. There were several bags of confidential waste stored in a cupboard waiting for uplift. No person identifiable information was visible to the public. Some team members had also read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people this. A safeguarding concern a few months ago had been documented and advice sought from the pharmacy superintendent. The pharmacist had contacted the person's GP and appropriate action was taken in a timely manner. The pharmacist at the time of inspection was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy now has enough team members to provide its services. This is achieved in different ways and new team members are being trained to enable the pharmacy to be self-sufficient. Team members can make decisions within their competence to provide safe services to people. And they can use their professional judgement. The pharmacy is working on setting aside time for team members to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy had been very short-staffed and had not had a regular pharmacist for many months and had found recruitment challenging. This had led to some of the difficulties, closures and mistakes over the past few months. And due to this some routine tasks had not been undertaken. This included processing prescriptions. A team member felt this could have contributed to ongoing staff shortages as the company staff profile used prescription numbers as part of the formula for staffing levels. Many prescriptions for medicines that had been supplied by instalment had not yet been processed and were stored in a basket at the time of inspection.

The pharmacy now had the following staff: one part-time (one day per week) accuracy checking pharmacy technician (ACT), one full-time and two part-time dispensers, one part-time trainee dispenser, one part-time experienced medicines counter assistant, two newly recruited team members who would initially work on the medicines counter, and a delivery driver. One team member had started the day before and was a qualified medicines counter assistant. She was reading SOPs at the time of inspection. The other new team member had started three week ago and had no previous pharmacy experience. She was mainly observed to be dealing with people's requests and queries on the phone and over the counter. At the time of inspection there was a locum pharmacist who had not worked in this pharmacy before, a relief dispenser who had been here a few days before, the experienced medicines counter assistant and the two new team members. Team members were able to manage the 'walk-in' workload. But there was a backlog of multicompartment compliance pack and routine dispensing. An area manager and an ACT were due to come to the pharmacy in the afternoon to dispense as much as possible. There was an expectation of two pharmacists and an ACT the following day, so the emphasis was on dispensing which would be accuracy checked the following day. The Divisional Quality Manager (pharmacist) was also in the pharmacy during the inspection and planned to dispense later that day. She was in the area and in this pharmacy to monitor progress and support teams as required. She explained to the inspector the strategies in terms of staffing and completing the action plan that were in place. A permanent pharmacist was due to start in around four weeks. The full-time dispenser who was on annual leave at the time of inspection had started in the pharmacy a few months ago and had management responsibilities. She had been supported by area managers to try and address the issues. Over the past few weeks an experienced pharmacist/area manager had spent a lot of time in the pharmacy supporting the team to review and improve systems.

The pharmacy provided learning time during the working day for the new team members to read SOPs. Over the last several months regular training during the working day had not been possible. But this was being addressed for accredited courses and on-going learning and development through the internal action plan. The team had an action to catch up with the past three months' training. There had been no development meetings held recently but addressing this was also in the action plan. The

experienced team members were observed going about their tasks in a systematic and professional manner. And the new team members were asking their experienced colleagues relevant questions. Experienced team members made decisions within their competence and used their judgement to keep people safe. The relief dispenser was observed to call a GP practice then impart relevant information to a person waiting for medicines. He did this autonomously but kept the pharmacist updated of his actions which were appropriate.

The experienced pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They felt they could share and discuss these. The team had recently started using the company 'Safer Care' programme and having team meetings. The first review and meeting had focussed on controlled drugs as there had been several running balance discrepancies and many recording errors over the past few months. And these had not been managed as they should, or the SOPs followed. The company had a whistleblowing policy that some team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and suitable for its services. It has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed. Some staff areas are dirty.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and a first-floor area including an office, two rooms used for the management of multi-compartment compliance packs, storage cupboards and staff facilities. The premises were well maintained but untidy, cluttered and dirty in some staff areas. Cupboards were cluttered with obsolete stock, waste medicines to be uplifted and confidential waste to be uplifted. Team members cleaned surfaces and touch points according to a rota, but this was not observed. Dispensing benches had some dirty marks in places. There were sinks in the dispensary, consultation room, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. But the sinks in the staff areas were dirty. There was hand sanitiser 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 which was clean and tidy, and the door closed providing privacy. This room was not large enough for full social distancing, but team members managed this as well as they could, maintaining as much distance as possible between themselves and other people. The pharmacy also had a separate area for specialist services such as substance misuse supervision. A team member called people into this area when it was free. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people access its services which it now provides safely. Pharmacy team members follow written processes relevant to the services they provide. The pharmacy obtains medicines from reliable sources and mostly stores them properly.

Inspector's evidence

Due to difficulties staffing the pharmacy, and in agreement with the health board, the pharmacy was now open 9am - 6pm rather than 9am – 8pm. It had a notice on the door telling people. But it also still had a notice with the previous hours of opening which could be confusing for people. The pharmacy had good physical access by means of a level entrance and a power assisted door. It listed its services and had leaflets available on a variety of topics. And it had posters signposting people to other services e.g. drug problem services. The pharmacy provided a delivery service and kept records of deliveries of certain medicines. Over the past few weeks some people had complained to other stakeholders about not receiving medicines on the correct day. The delivery driver was not present and other team members present were not aware of these incidents. But they thought the issue was related to times when there had not been a pharmacist. The Divisional Quality Manager explained that each incident was being investigated.

Pharmacy team members now followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. Team members had recently reviewed the dispensing process. Previously there had been examples of them not able to find prescriptions and medicines. But the new system involved electronically scanning prescriptions upon receipt from the surgery then filing them alphabetically. The dispensing process involved labelling then assembling prescriptions from this box. But this process was up to a week behind. At the time of inspection there were a lot of prescriptions in this box file; some had been there for a week waiting to be dispensed. When people came to the pharmacy to collect their medicines team members looked on the retrieval shelves. If the medicines were not there, they could locate prescriptions and dispense them while people waited. Although prescriptions were found quickly, dispensing while people waited introduced a risk due to pressure. Until the process had been improved, team members spent a lot of time trying to locate prescriptions as they were not stored methodically. Team members were also dispensing 'walk-in' prescriptions continually. They 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 sometimes this was delayed due to staff shortages. The pharmacy now had an effective filing system for these prescriptions, so if they had not been dispensed, team members could locate prescriptions quickly when people came to the pharmacy to collect their medicines. Team members present at the time of inspection did not think that the pharmacy had any 'Medicines Care Review' (MCR) serial prescriptions.

The pharmacy supplied medicines to a lot of people in multi-compartment compliance packs. It managed the dispensing and the related record-keeping for these on a four-weekly cycle. Over the past few months this process had become inefficient and the pharmacy had made some mistakes. Recently the team had reviewed the process, overhauled it and re-implemented it in line with the SOP.

Team members assembled four weeks' packs at a time, usually one week before the first pack was due

to be supplied. But at the time of inspection, packs were being assembled for supply the following day. And the pharmacy had not ordered prescriptions for a pack due for supply that day. The relief dispenser contacted the GP practice to confirm that there were no changes to the usual repeat medication, then discussed it with the pharmacist who agreed the pharmacy would supply the medicines using the urgent supply Patient Group Directive (PGD). The dispenser explained the delay to the person's representative and gave a realistic time for collection. The medicines were supplied as agreed. Team members had re-written people's records cards to provide clarity regarding changes to medication or other interventions. And they had changed the storage system making it clear and straightforward to locate medicines. They wrote instalment numbers on the spines of packs. The date on the outside of the packs was the date of labelling, with the date of supply in small print on the backing sheets. They included tablet descriptions on some packs. And they provided patient information leaflets with the first pack of some prescriptions. The pharmacy used two rooms on the first floor for this process. Team members undertook administration tasks, labelling, assembly and storage in the larger room. A pharmacist or ACT used the other room for carrying out the final accuracy checks. Pharmacists initialled prescriptions that they had clinically checked to enable the ACT to complete the final accuracy check. The pharmacy supplied a variety of other medicines by instalment. This process had also been reviewed and improved recently. A team member either dispensed these prescriptions in their entirety when the pharmacy received them, or dispensed them weekly, depending on the instalment interval and the space required to store 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 alphabetically in individually named baskets on dedicated shelves.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. They 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. Team members present were not experienced in this pharmacy, but trained dispensing team members knew what this entailed. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and chlamydia treatment. A few pharmacy team members knew about the Pharmacy First service and referred requests for advice to the pharmacist. The pharmacy was not delivering any other services.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. Some medicines were stored in totes upstairs for using in multi-compartment compliance packs. But these were untidy with different medicines stored together, increasing the risk of selection errors. There were some shortages and the pharmacy had unexpectedly run out of some items e.g. diazepam and Epilim Chrono ® tablets. A team member explained this could be due to stock counts not being done or 'order-up-to' levels being wrong. Mostly team members used space well to segregate stock, dispensed items and obsolete items. They had tidied cupboards and storage areas over the past few weeks. This had highlighted some obsolete stock. The pharmacy stored items requiring cold storage in two fridges and team members usually monitored and recorded actual, minimum and maximum temperatures daily. But there were no temperatures recorded some days. They took appropriate action if there was any deviation from accepted limits. Team members 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 Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts. 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. Team members look after the equipment to ensure it works, and don't provide the service if the equipment is not fit for purpose.

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 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 which was maintained by the health board, a blood pressure monitor and a blood sugar meter which was not being used as it had not been calibrated recently. Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy used a 'Methameasure' pump for measuring methadone solution. Team members cleaned it at the end of each day and poured three test volumes each morning when they set it up. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets. And marked tweezers for handling cytotoxic tablets. The pharmacy had obtained and labelled these recently following a review of equipment.

The pharmacy stored paper records in the dispensary and other areas of the pharmacy inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented people in the retail area seeing other people's personal information. 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.