General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 115 Corstorphine Road, EDINBURGH, EH12 5PZ

Pharmacy reference: 1125510

Type of pharmacy: Community

Date of inspection: 19/09/2019

Pharmacy context

This is a community pharmacy on a main road in a city suburb. The pharmacy dispenses NHS prescriptions, private prescriptions, and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental compliance packs, supplies medicines to a care home and provides substance misuse services.

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 manage all risks effectively. The team does not always follow standard processes, such as near miss recording, date checking, fridge temperature monitoring and the procedure relating to managed repeat prescriptions.
		1.2	Standard not met	The pharmacy does not routinely monitor and review the safety and quality of its services. And the team members don't record their near miss errors. So, there is the risk they don't learn from mistakes or make improvements to services.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough qualified and experienced staff members to safely deliver its services in a timely manner. And this has led to a backlog in the workload and an untidy environment. The current staff do not always have the knowledge of the pharmacy to manage the workload effectively, as they do not work regularly in the pharmacy.
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 team, due to pressure and workload, doesn't follow robust processes to ensure the safe and effective delivery of services. Some patient group directions are out of date. And the pharmacist may be missing opportunities to make clinical interventions, such as for valproate and for interactions between medicines.
		4.3	Standard not met	The pharmacy team doesn't regularly complete the required checks on medicines and equipment to make sure medicines are fit for purpose. Some medicines are out-of-date. And fridge temperature monitoring is inadequate.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team follows written processes for some but not all its activities. So, it doesn't manage all its risks effectively. And team members do not record mistakes that happen whilst dispensing. So, they are missing opportunities to learn from these. And to make changes so processes can be safer. The pharmacy keeps most of the records that it needs to by law and keeps people's private information safe. Team members help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for some activities and tasks. Some pharmacy team members had read them, and the pharmacy kept records of this. But some team members who had previously worked in other branches had not yet read and signed them in this pharmacy. The pharmacy had received new SOPs for some processes two months previously, but team members had not yet read these. The team did not follow all SOPs, such as recording near misses. The pharmacy superintendent reviewed the SOPs every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and individual records of competence were kept. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy had faced staffing and leadership challenges recently, causing dispensing to be behind, leading to some untidiness in the dispensary. The team had ordered a lot of medicines for stock and to enable care home dispensing to be undertaken, so the dispensary looked cluttered, and dispensing space was limited. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It had a 'One Call' menu on the dispensary wall, so issues could be notified to the appropriate department in a timely manner. The area manager had recently reviewed the workload in the pharmacy and moved one of two care homes' dispensing to another branch with greater resource and space.

Team members did not record near miss errors that were identified in the pharmacy. They had identified that they were not doing this, so had initiated a record book the previous week. But only two incidents were recorded. And team members acknowledged that this was not representative. They did not describe any improvements that they had made. They were also not undertaking the weekly safer care audits that were part of an internal process to identify and address risk.

The pharmacy had a complaints procedure and welcomed feedback although no examples could be described. A team member described ordering a product not usually stocked for one person.

The pharmacy had an indemnity insurance certificate, expiring 30 June 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; 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. But the filing of CD registers was untidy.

The pharmacy had filed alfentanil registers in the morphine section. This could mean that additional registers were opened as they would be difficult to find. And there were two registers open for Mezolar 12mcg/hour patches which was not lawful. Some registers were no longer 'bound' and needed repair.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and undertook mandatory annual training. They segregated confidential waste for secure destruction, but there were several bags in the basement waiting to be uplifted. No person identifiable information was visible to the public. Team members had also undertaken training 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. The pharmacists were PVG registered.

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

Summary findings

The pharmacy does not always have enough qualified and experienced staff members to safely deliver its services in a timely manner. And team members do not have opportunities to undertake ongoing training and development during the working day. They informally discuss what tasks need completing whilst working, as they don't hold regular meetings. This means they may not be working in the most effective way.

Inspector's evidence

The pharmacy had the following staff: one full-time dispenser who had worked in this pharmacy for three months; one part-time (9am – 3pm) dispenser who was leaving the pharmacy in four weeks' time; one part-time (9am – 2pm Tuesday – Friday) medicines counter assistant; one part-time dispensing assistant (Monday, Friday and Saturday); one part-time delivery driver. The pharmacy had not had a regular pharmacist for around five months. It relied on a variety of relief and locum pharmacists for short spells or individual days. So, typically the pharmacy was staffed with only a locum or relief pharmacist and one dispenser in afternoons. Sometimes the pharmacy had additional pharmacist cover to help with workload and leadership. A relief accuracy checking technician sometimes worked in the pharmacy to check care home dispensing. At the time of inspection, the part-time pharmacist from another branch was doing this. The pharmacy had not managed to undertake all routine tasks due to staff shortages in recent weeks. These included date checking, training, accurate filing and counting of prescriptions, company safer care audits, and recording near miss errors identified in the pharmacy. The cluster manager had undertaken controlled drug running balance audits but not tidied the way records were filed. The manager described how she managed these tasks in another branch and intended to mimic these processes in this pharmacy.

The pharmacy had raised concerns with the area manager who had recently addressed the staffing situation. A full-time non-pharmacist manager (who was a dispenser) and a part-time pharmacist from another branch had been in this pharmacy for the past three weeks. And a relief dispenser worked in this pharmacy when she was available. At the time of inspection there were two pharmacists, manager (dispenser), three dispensers including the relief dispenser, and the medicines counter assistant. They were able to manage the workload despite some backlog. Their main challenges were lack of continuity, and individuals not all familiar with this pharmacy. The manager was recruiting for an afternoon medicines counter assistant, a Saturday assistant and either one full-time or two part-time dispensers.

The pharmacy did not provide regular protected learning time for team members to undertake training and development. They did not have opportunities to identify their training or development needs. A team member described not having time at work to undertake NVQ 3 training. When she commenced training, the intention was for the pharmacy to provide protected time. The team did not hold meetings to discuss and share information or incidents. But they shared information about people, prescriptions and medicines 'on-the-job'. The team had not used a communications book since January 2018, and one labelled for the care home had no entries. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. But some team members were not aware of this. The pharmacy did not circulate this to all team members. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. But due to recent staffing issues these were not being pursued.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. People cannot overhear these conversations.

Inspector's evidence

These were small premises incorporating a retail area, dispensary and basement area including very limited storage space and staff facilities. The dispensary was small for the volume of dispensing. A pharmacist checked some dispensed medicines in the staff area to free space. All areas were cramped and congested. The pharmacy had to store all rubbish on the premises until it was uplifted as there was no facility for external storage. It had a lot of general waste, confidential waste, waste medicines and re-cycling waiting to be uplifted. At the time of inspection, a large medicines order had been received so there were around 30 tote-boxes, mainly in the dispensary. The pharmacy also had many tote-boxes containing dispensed medicine for the care home which was due to be supplied the following week. A team member contacted the home to arrange to deliver some medicines early to free some space. The premises were clean, hygienic and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. Temperature and lighting were comfortable.

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.

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

Summary findings

The pharmacy has processes to manage and deliver its services safely and effectively. But due to recent staff shortages increased pressure and workload has affected the ability of the pharmacy team to provide its services to the standards required. Sometimes the pharmacy cannot offer some services at all. And some of the service specifications are out of date. The pharmacist may be missing the opportunity to address clinical concerns, including raising them with prescribers. The pharmacy obtains its medicines from reliable sources. But some medicines may not be fit for purpose as they are out of date. And the pharmacy has not been keeping regular records of the temperature in the fridge. The pharmacy mostly helps people to use its services but the high step at the entrance is challenging.

Inspector's evidence

The pharmacy had a high step at the entrance and hand rails to help people. It had a portable ramp stored in the consultation room, but this was very seldom used. A person using a wheelchair who received regular prescription medicines had stopped visiting the pharmacy due to the access difficulty. A family member collected her medicines. The pharmacy listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order and 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. At the time of inspection, the pharmacy was using a courier service due to driver absence. This was affecting timings, with the driver not collecting items from the pharmacy at the usual time. The pharmacy had requested an additional driver to ensure medicines were delivered to a care home at an agreed time. The multi-compartmental compliance packs were being delivered to people later than usual. The pharmacy usually delivered these in the morning, but they were now expected to be delivered late afternoon. The team didn't know if people had run out of their medicines. So, there was a risk that people couldn't take their medicines when they needed them. Team members were working hard making calls to improve this. They also needed space freed-up in the dispensary as there were more than 30 tote-boxes in the way.

Pharmacy team members 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. But due to congestion in the dispensary, some areas appeared cluttered. The pharmacy did not have a robust process to highlight potential interactions between peoples' medicines to the pharmacist. Team members highlighted interactions to the pharmacist either verbally or some used notes. Some team members told the pharmacist if there were any new items. The locum pharmacist explained that she used the list of medicines on the ‘repeat-slip’ to check for new items, and sometimes referred to the patient medication record (PMR). But some prescriptions did not have this part attached, especially for ‘walk-in’ prescriptions. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The team was reviewing how ‘managed repeat’ prescriptions were ordered and assembled. Recently team members had not been following the SOP and medicines were sometimes not ready as people expected. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacy managed multi-compartmental compliance packs on a four-weekly cycle with four assembled at a time. Team members followed the relevant SOPs and this process was currently ‘up-to-date’. The pharmacy had been behind with this process a few weeks previously, posing considerable

risk, but team members had worked hard to catch-up. They provided patient information leaflets with the first pack of each prescription and included tablet descriptions on backing sheets. The pharmacy was not taking on any new people's prescriptions for this service due to capacity. Team members had not carried out assessments for suitability on the people receiving these packs. The pharmacy also provided pharmaceutical services to one care home. The pharmacy managed the workload over a four-week period and usually delivered all medicines monthly. Recently the area manager had visited the home to discuss the service. The home had identified that the pharmacy did not always answer the phone, making it difficult to arrange supply of urgent medicines. Team members were trying to answer the phone as soon as possible to address this.

The pharmacy supplied a variety of other medicines by instalment. Team members tried to dispense these the week before supply. A few weeks' previously medicines were dispensed as people arrived at the pharmacy. Which caused pressure and increased the risk of mistakes. The pharmacy did not have any chronic medication service (CMS) serial prescriptions. And they were not promoting this core service. So, people were not benefiting from any aspect of CMS.

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 kept written information to be supplied to people beside valproate products. A team member explained that a person in the risk group who stayed in a care home had been identified. The pharmacy had planned to discuss this with the care home team but had not yet done this. 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. But some PGDs were out of date. And not all locum pharmacists were signed up to deliver them all. So, the pharmacy could not deliver all services each day which was confusing and not satisfactory for people. Or they may be supplied with medicines inappropriately if the team followed out-of-date processes or criteria. The part-time pharmacist from another branch was reviewing these and identifying improvements required. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence. 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.

The smoking cessation service was delivered by pharmacists, but the recent lack of continuity and leadership contributed to there being no-one accessing this service currently. Two team members were trained to measure blood pressure. They provided this service for some people receiving medicines from an online prescribing service as part of the service specification. The pharmacy had stopped offering the diabetes testing service due to other workload pressures and only one team member was trained. It was not offering a flu vaccination service this year as there was no regular trained pharmacist. It had offered this in previous years. This could put additional pressure on other pharmacies in the community.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). A few team members had undertaken some training and the equipment was available. But medicines were not being scanned. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It kept

medicines on the local palliative care list although it was not part of the network. People in the care home sometimes required these.

It stored items requiring cold storage in a fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. But the fridge was congested. And records of temperatures were incomplete and unclear. The pharmacy did not have any temperatures recorded for the previous month (August 2019) but there were several sheets of records with no month or year noted. The temperatures had been recorded recently and were within range at the time of inspection. Team members regularly checked expiry dates of over-the-counter medicines and those inspected were found to be in date. But the pharmacy had no recent evidence of checking dates of prescription medicines, the last date recorded five months previously. And several items inspected were out of date e.g. omeprazole 40mg expired in March 2019, and others were out of date at the end of the current month e.g. olanzapine 7.5mg. 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, and a blood pressure meter which was replaced as per the manufacturer's guidance. Team members kept crown stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy team also kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in a locked cupboard in the consultation room 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?

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.