General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 2a Hamilton Square, Murieston, Hamilton Square, Livingston, West Lothian, EH54 9JZ

Pharmacy reference: 9010237

Type of pharmacy: Community

Date of inspection: 12/05/2021

Pharmacy context

This is a community pharmacy attached to a health centre. 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 suitably identifies and manages the risks with its services, including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law and keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter, hand sanitiser at the premises entrance, and face masks to offer to people who entered the pharmacy not wearing one. The pharmacy had marked the floor to encourage people to socially distance and follow a one-way-system. It allowed two people on the premises at any time and had notices up explaining this to people. 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. They cleaned surfaces and touch points several times during the day. A team member cleaned the consultation room immediately after use. The pharmacy had carried out a personal risk assessment with each team member to identify any risk that needed to be mitigated in the pharmacy. No such risks had been identified.

The pharmacy had standard operating procedures (SOPs) which team members followed. Pharmacy team members had read them, and the pharmacy kept records of this. A team member who had recently returned to work in the pharmacy was in the process of reading the SOPs. She was reading a few each day to avoid being overwhelmed. And a senior team member was confirming that she understood and was following them. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on their individual record sheets. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. A medicines counter assistant described how she helped deliver services such as Pharmacy First and was clear about the scope of her role. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. Team members kept it close to the pharmacist's checking bench so that it was easily accessible. And the emergency key holders' list was in the dispensary including contact details for the alarm company.

Team members used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors each month to learn from them. And they met to discuss incidents. Notes of a recent meeting identified distractions such as phone calls contributing to errors. Some errors had involved similar looking or sounding medicines. Team members had discussed keeping drawers and shelves tidy, always dispensing from prescriptions rather than labels, and not rushing when dispensing. They had separated some similar looking medicines. The pharmacy also carried out other audits following the company's 'Safer Care' programme. It was noted that one audit had recorded bringing COVID safety measures in, including cleaning and team members

wearing PPE. The pharmacy had a complaints procedure and welcomed feedback. Several examples of positive feedback regarding people's experiences were observed. A person had raised a concern about dispensed medicines not being ready as expected. Team members were aware of this and had discussed the issue with the area manager and surgery staff. People had unrealistic expectations of when their medicines should be ready. The pharmacy had put up notices explaining when medicines would be ready, four days after ordering the prescription at the GP practice. But team members still had to explain this to people. And during the inspection people came to the pharmacy too early, usually two days after ordering. Team members dealt well with the situation, politely explaining when medicines would be ready. But they typically prioritised dispensing in this situation to avoid the person having to come back.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2021. The pharmacy displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. All records were accurate and up to date. The NHS CD authorised witness had recently witnessed destruction of obsolete stock items and the pharmacy was up to date with destruction pf patient returned medication. Records of these destructions were observed. 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 company policies. They segregated confidential waste for secure destruction. An external contractor uplifted the bags which were clearly marked. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern, initially by contacting the pharmacy superintendent's office. They were aware of initiatives to support victims of domestic abuse, particularly 'ask for ANI'. A team member explained that the team had discussed this initiative and made a collaborative decision not to display the show material related to this initiative. They were worried that a victim's partner would see the information and know that's why the person had gone to the pharmacy. They felt that there was high awareness from media advertising. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles and the services they provide. The pharmacy gives them time for reading and training during the working day to keep their knowledge up to date. Team members make decisions within their competence to provide safe services to people. They know how to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time equivalent pharmacist, one full-time trainee pharmacy technician (PT), two part-time dispensers, three part-time medicines' counter assistants, and a part-time delivery driver. Typically, there were three or four team members and a pharmacist working at most times. At the time of inspection there was a locum pharmacist, the trainee PT, two dispensers and a medicines' counter assistant.

They were all experienced and able to manage the workload. The trainee PT had just started her course that week. She anticipated being able to undertake some of her training at work and explained how the pharmacy had given her five hours one week to complete the assessments for registration on the course. She had also just been appointed as manager of the pharmacy. She demonstrated enthusiasm and competence for both roles. She was aware of the importance of the management role as there was not a permanent pharmacist in the pharmacy, and she was the only full-time team member. The pharmacy had a list on the wall of the locum/relief pharmacists that were working over the following few weeks. This helped the PT plan some work and tasks, with more being able to be done when the same pharmacist was working on consecutive days, or when a pharmacist familiar with the pharmacy was working. The pharmacist working at the time of inspection had worked a few days in this pharmacy and explained she felt settled and welcomed, and team members were following robust systems. Part-time team members had some flexibility to cover absence. There was currently one person off. The pharmacy had recently recruited and two new team members working part-time, mainly Friday and Saturday were starting soon. The PT was looking forward to them starting and had planned for their induction and on-going training. The pharmacy gave all team members time to read information and complete training as required. This included reading the regular company update document the 'Daily Dose', and 'My Knowledge' training modules when they were available.

Team members were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The medicines' counter assistant described the challenges of a product intended for short-term use being very popular and people frequently requesting it. She explained to people that this medicine should only be used for a few days and signposted them to their GP. But this had been difficult during the pandemic when GPs were not seeing many people in person. She often referred these requests to the pharmacist.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own. They had an open environment in the pharmacy where they could share and discuss these. They had weekly meetings to discuss incidents. They could make suggestions and raise

concerns to the manager or area manager. Team members described an open and friendly environment where they shared work and personal information continually and supported each other. They acknowledged how difficult it had been during the pandemic and how friendship of work colleagues had been invaluable. They used a whiteboard to share important dispensing information and reminders of tasks to be done such as date checking. And the medicines counter assistants used a diary for sharing information. This was observed when a team member highlighted to the PT that she had left notes for her colleague who would be starting her shift later the same day. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members described how they used these as a reminder to offer people services they would benefit from.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for delivery of its services. It has suitable facilities for people to have private conversations with team members. And it protects people’s private information. The pharmacy is secure when closed.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary, staff toilet facilities and an office area. There was little storage space. The premises were clean, hygienic and well maintained. There were sinks in the dispensary and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available.

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 large enough for social distancing and this was managed by positioning chairs as far apart as possible. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services. And it provides these services safely. Pharmacy team members follow written processes. They support people by providing them with information and suitable advice to help them use their medicines. And they provide extra written information to people taking higher-risk medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. It had a hearing loop in working order for people wearing hearing aids to use. And it could provide large print labels for people with impaired vision. All team members wore badges showing their name and role. The pharmacy provided a delivery service and the driver followed standard COVID hygiene measures.

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. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy sent managed repeat prescriptions to an offsite 'hub' for dispensing. It managed this following the company procedures and people knew that their medicines were prepared off-site. The pharmacy managed repeat prescriptions on a four-week cycle which streamlined the dispensing and storage of medicines. This system was observed to work well and they could locate prescriptions efficiently. The pharmacist checking prescriptions marked them with the day and week they had been dispensed. And stored them in boxes by day and week which made it efficient to locate medicines. This also helped team members identify uncollected medicines. They texted people whose medicines had not been collected within a month and re-located these medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these the week before they were required to ensure the medicines were ready on time. It worked on an eight-week cycle, so dispensing in week seven. And team members recorded when people collected their medicines to monitor compliance. The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle in a specific area of the dispensary. Team members assembled four weeks' packs at a time, one week before the first pack was due to be supplied. They kept comprehensive records of interventions and changes. They only made changes when they received a written and signed request from the prescriber. These requests were kept, and the person's record sheet was updated. This ensured that medicines supplies were accurate, and the thorough system made it straightforward for any team member to follow the process at any time. Team members included tablet descriptions on backing sheets. They also signed and dated them to show who had dispensed and checked the medicines. And they supplied patient information leaflets with the first pack of each prescription. The pharmacy stored completed packs in individual labelled boxes on dedicated shelves. They were marked with the day of supply and either delivery or collection. Each day a team member placed the packs for delivery the following day into labelled bags and placed them into that day's delivery box. The pharmacy supplied a variety of

other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply.

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. It had undertaken a search for people in the 'at-risk' group. The pharmacy did not supply valproate to anyone in this group. But it had information available to provide to people if required and team members knew where this was stored. 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. The locum pharmacist described having signed these in different health board areas where she worked. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They completed a template capturing relevant information before referring to the pharmacist. And 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. During the pandemic the pharmacist had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy. The pharmacy had provided seasonal flu vaccination during the season. The pharmacist at that time was trained to deliver the service and followed strict infection control measures including using personal protective equipment (PPE) and cleaning the consultation room after use. And the pharmacy had previously offered blood pressure measurement and diabetes testing. It had not offered diabetes testing during the pandemic for infection control reasons. Early in the pandemic the GP practice had sent people to the pharmacy either to have their blood pressure measured or to purchase blood pressure meters. Team members trained to measure blood pressure had also followed strict infection control measures.

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. And team members used space well to segregate stock, dispensed items and obsolete items. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. Team members regularly 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. A team member described how she and colleagues managed inappropriate requests for medicines intended for short-term use.

The pharmacy actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety 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 to deliver its services. And team members look after it to ensure it works.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy 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, a blood pressure meter, and blood testing equipment for diabetes testing. Team members were not using this equipment during the pandemic to reduce the chance of spreading infection. The pharmacy kept ISO-marked measures by the sink in the dispensary, and separate marked ones were used for methadone. And it had clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary and office inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.