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: 29/07/2022

Pharmacy context

This is a community pharmacy in Livingston. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

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 identify all the risks associated with implementing a new operating system. And it has not put sufficient safety measures into place to maintain safe and effective working practices.
		1.6	Standard not met	The pharmacy does not have robust processes to maintain the legal records it needs to by law, including the responsible pharmacist record using the new operating system.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy team struggles to manage the workload and at the same time acquire new skills to use the updated computer system effectively. This impacts on the pharmacy team's capacity to provide pharmacy services safely and effectively.
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 not all met**

Summary findings

The pharmacy does not identify all the risks associated with its services, especially when introducing new operating systems. And its record keeping is not robust. This includes the record of which pharmacist is in charge of the pharmacy and when. The pharmacy keeps people's private information secure. And pharmacy team members appropriately recognise and respond to safeguarding concerns.

Inspector's evidence

The pharmacy had introduced new processes to manage the risks and help prevent the spread of coronavirus. And the company had installed a protective plastic screen at the medicines counter to protect team members and members of the public. Pharmacy team members used hand sanitizer. And they wore face masks throughout the day. The company used documented working instructions to define the pharmacy's processes and standard operating procedures (SOPs). And team members annotated records when they had read and understood them. The company had changed the way they introduced new procedures. And it assessed the team members understanding through a series of questions they had to answer correctly. The dispensers confirmed they had successfully answered the questions following the recent introduction of new 'responsible pharmacist' and 'controlled drug' SOPs. The pharmacy employed a non-pharmacist manager to support the responsible pharmacist and the other team members. At the time of the inspection, they were working at a nearby branch that was experiencing staffing shortages. The company expected branches to follow its audit and monitoring schedule. This was intended to assess compliance with its processes and procedures. And to identify risks and support team members to make the necessary improvements to keep services safe. Team members had not completed any audit and monitoring activities since March 2022. This was partly due to the introduction of a new pharmacy operating system and the transitioning to new ways of working.

Dispensers signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This created an audit trail and meant the pharmacist was able to help individuals to learn from their dispensing mistakes. The company expected team members to record their own near miss errors. But sampling showed they had last recorded errors around March 2022. They agreed the records did not reflect the actual number of near miss errors. And they were relying on the new pharmacy operating system to support accuracy in dispensing. This involved the use of a bar code scanning facility that identified some types of errors, such as selection errors at the time of dispensing. Team members knew to record dispensing incidents on an electronic template. And there was evidence to show they had recently used the reporting process. Team members had not developed the necessary competencies to operate the new system. This was due to time constraints and not having access to onsite training. The new system had also failed from to time. And team members had needed to contact the company's helpdesk who had helped to resolve the issues. Team members recognised the risk of having exceptionally high stock levels of medicines. But they had little control over the stock as a result of not fully understanding the new system. Storage drawers were congested, a dispensing bench was being used to keep stock and team members were dispensing from totes that had just arrived. The Area manager and Divisional Quality Manager had visited to develop an improvement action plan to address some of the identified issues. This included plans for the recruitment and retention of new staff. The pharmacy trained its team members to manage complaints. It had defined the complaints procedure for team members to refer to. The pharmacy provided information about its complaints process in a

company leaflet that it displayed for people to self-select. The number of formal complaints had increased significantly. This included complaints about long waiting times, prescription items not being ready when they should have been and out of stock items.

Team members did not always keep the records they needed to by law up to date. The pharmacist displayed a responsible pharmacist (RP) notice, and it was visible from the waiting area. But they could not produce the RP record and could not show it was up to date. The pharmacy manager, who returned to the pharmacy towards the end of the inspection, believed this to be due to the new operating system that the company had recently introduced. This meant there was no information about which pharmacist had been responsible for the safe running of the pharmacy. Team members maintained the controlled drug registers and records showed they had recently conducted a balance check of all items. They used a CD destruction register to document items that people had returned for disposal. And the pharmacist had signed to confirm they had been safely disposed of. Team members filed prescriptions so they could be easily retrieved if needed. They kept records of supplies against private prescriptions and supplies of 'specials'. But the records of private prescriptions were incomplete, and the register showed missing entries from around May 2022. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. Team members used a designated container to dispose of confidential waste. And an approved provider collected the waste for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And it provided a policy for them to refer to. This included contact details for local agencies. Team members knew to speak to the pharmacist whenever they had cause for concern. This included concerns about failed deliveries or collections of medication for vulnerable people. They gave an example of a concern they had raised and resolved. The pharmacy liaised with team members at the medical practice next door. And communicated unplanned closures due to staffing shortages. The medical practice helped to mitigate the risks of closures. This included issuing new prescriptions for people to take to other pharmacies.

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

Summary findings

The pharmacy team struggles to manage the workload and at the same time to acquire new skills to use a new operating system. The pharmacy team is behind with some routine tasks. And this increases the risk of the team making mistakes. Team members have the qualifications for the roles they are expected to undertake. And they receive some protected learning time.

Inspector's evidence

Records showed that the number of prescriptions the pharmacy was dispensing had fallen since the same time the previous year. But team members could not confirm the accuracy of the numbers as they had fallen behind with tasks. A locum pharmacist was providing cover at the time of the inspection. And the pharmacy had been running with different pharmacists most days since the regular pharmacist left in March 2022. A non-pharmacist manager was in post. But they had been working at a nearby branch to provide support due to staffing issues. The pharmacy had started to experience significant staffing issues in June 2022. This was due to team members leaving at the same time, others being on planned annual leave and long-term absences. A new pharmacy operating system had been adding to workforce pressures as team members did not fully know how to use the system. They had not been able to complete the training the company had put in place to facilitate the introduction of the new system. The following team members were in post; one full-time pharmacist, one full-time non-pharmacist manager (dispenser), one part-time dispenser who worked mostly on the medicines counter, one Saturday dispenser who worked over-time to provide cover, two part-time dispensers and one new part-time team member who was undergoing induction training.

Although the company had recently recruited a new team member, an experienced team member was about to leave to take up another post. The non-pharmacist manager was also working at a nearby branch to provide support due to staffing issues. And this was also causing ongoing instability in the workforce. Team members had regular contact with the area manager who was aware of the staffing issues and extra pressures in the branch. And they tried to arrange cover. But this was not always available, and some team members who were sent from other branches were not always trained to use the new system. The company had recognised the issues in the pharmacy, and this had triggered an on-site visit from the area manager and the divisional quality manager. And they had implemented an action plan to facilitate improvements at the branch. This included actions to improve staff numbers and this was ongoing. At the time of the inspection there was evidence to show that team members were under pressure managing the current workload. The company had authorised the pharmacy to send prescriptions to an off-site dispensary for hub dispensing. But they had removed this authorisation due to an unacceptable number of labelling errors, that had not been identified in the pharmacy before the prescription data went to the hub. And team members were going through a re-validation process to evidence improvements in labelling accuracy. The company had not provided extra team members to manage the extra workload this created. A team member was dispensing the multi-compartment compliance packs that were due the following week. This was to help reduce the pressure on team members having to cover another dispenser’s annual leave. The manager had provided some protected learning time for team members to read the new SOPs. And this had helped team members complete the online training required for the new operating system. They had not had access to onsite training that was delivered face-to-face by a company trainer.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are adequately clean and suitably secure. The pharmacy has a suitable consultation room where people have private conversations with team members. Overall, it has sufficient storage space for its medicines. But the lack of stock management control means the team has reduced space for dispensing. And this may increase the risks of mistakes.

Inspector's evidence

The pharmacy had restricted storage space for its stock levels. And team members were using one of its dispensing benches to keep excess stock. This was due to a new pharmacy operating system and the team's lack of understanding about how to use it. The reduction in dispensing space was creating congestion on the main dispensing bench. A separate rear bench was kept clear and mostly used to assemble multi-compartment compliance packs. This managed the risk of items being mixed up. The checking bench faced out onto the waiting area. And the responsible pharmacist supervised the medicines counter and intervened when they needed to. The pharmacy had a sound-proofed consultation room which provided a confidential environment for private consultations. The room was used solely for consultations and was professional and clean in appearance. Team members cleaned and sanitised the pharmacy to reduce the risk of spreading infection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy adequately manages its services to help people receive appropriate care. It gets its medicines from reputable sources. And the team carries out checks to make sure medicines are in good condition and suitable to supply. It has arrangements to identify and remove medicines that are no longer fit for purpose. But it doesn't always manage the stock levels of its medicines as well as it could.

Inspector's evidence

The pharmacy had a step-free entrance and provided unrestricted access for people with mobility difficulties. The pharmacy advertised its services and opening hours in the window. But it had experienced recent unplanned closures due to staffing issues. And people's access to medicines and services had been disrupted. Team members liaised with the medical practice next door to ensure that people were directed to another pharmacy. And they knew to contact vulnerable people to provide them with extra support so they did not go without their medication. The health board had recently authorised the pharmacy to reduce its opening times. And this had helped the pharmacy team to gain better control over their workload.

The pharmacy was overstocked due to a new operating system. It had a system of drawers for stock. And these were congested which made it difficult for team members to keep items separated. They didn't always have enough time to put away the daily stock order they received. And they had to pick items directly from the totes that were seen next to the shelves and this was time-consuming. Team members kept the controlled drug cabinets neat and tidy. And items were safely segregated in baskets. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members described how they followed date-checking procedures to manage the risk of stock expiring. They could not produce records to evidence they had completed checks. Sampling showed items were within their expiry date. The pharmacy supplied medicines in multi-compartment compliance packs to people that needed extra support with their medicines. The new operating system was used to manage dispensing. And team members checked each prescription against the person's medication record before printing the backing sheet which they attached to each of the packs. The backing sheet detailed the medications in the pack, times of administration and warning labels. The pharmacy had defined the assembly and dispensing process in a documented procedure for team members to refer to. This was up to date. Shelving to store the packs was kept neat and tidy.

The pharmacy had been sending some repeat prescriptions to an off-site dispensing hub. These were mostly serial prescriptions for people that had registered with the ‘medicines care review’ service (MCR). The dispensers entered prescription information onto the system which was used to generate dispensing labels. And the pharmacist carried out clinical checks and checked the accuracy of the information before they released the prescriptions to the hub for dispensing. But the hub had identified an unacceptable level of labelling errors that had gone undetected in the pharmacy and the company had removed the facility. Team members were going through a process of re-validation to show they had improved accuracy in labelling. This had put extra pressure on the pharmacy team as they had to manage the increased workload this caused without any extra resources to support them. The pharmacy used a fridge to safely segregate stock and manage the risk of selection errors. It was well-organised, and team members monitored and documented the temperatures. Team members knew

about valproate medication and the Pregnancy Prevention Programme. And they knew to supply patient information leaflets and to provide warning information cards with every supply. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy prioritised drug alerts and team members knew to check for affected stock so that it could be removed and quarantined straight away. A team member checked a recent drug alert for ketamine injection. And they followed the company's procedure which included updating the electronic alert system.

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 access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for methadone. They had highlighted the measures, so they were used exclusively for this purpose. A blood pressure monitor was available. And had been dated April 2023 to show when it next needed to be calibrated. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could carry out conversations in private if needed. The pharmacy used cleaning materials for hard surface and equipment cleaning. The sink was clean and suitable for dispensing purposes. Team members had access to personal protective equipment including face masks.

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.