General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloyds Pharmacy, 39 Westfield Road, Edinburgh, Midlothian, EH11 2QW

Pharmacy reference: 9010377

Type of pharmacy: Community

Date of inspection: 17/06/2021

Pharmacy context

This is a community pharmacy beside a supermarket and other shops on a main road into the city. It is in a residential area. It is open seven days a week with extended hours during the week. 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. It offers blood pressure measurement. This pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 help 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 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 and had marked the floor to encourage people to socially distance. It allowed four people on the premises at any time. And they were encouraged to use hand sanitiser which was at the medicines' counter. Most people coming to the pharmacy wore face coverings and team members reminded others to wear them if they could. This was observed. Team members wore fluid resistant masks. They also washed and sanitised their hands regularly and frequently. And they cleaned surfaces and touch points several times during the day. A team member cleaned the consultation room immediately after use. The pharmacy manager had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. No such risks had been identified. Team members carried out lateral flow COVID tests twice a week to identify asymptomatic infection and take appropriate action to protect each other and people using the pharmacy.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them at least every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and confirmed on individual record cards. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. They were clear about who could undertake some processes such as the assembly of multi-compartment compliance packs. Two dispensers were competent to do this. 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 used 'near miss logs' to record dispensing errors that were identified in the pharmacy, known as near miss errors. They reviewed all near misses errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. They had identified the times of the week when mistakes were more likely to happen, so were all reminded to take their time and ask for help if there was something new to them. And they were reminded to be careful with quantities and similar packaging. Team members had attached labels to drawers highlighting similar medicines' packaging. The pharmacy carried out weekly audits covering all aspects of the pharmacy each month. The pharmacy had a complaints procedure and welcomed feedback.

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 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 and signed company policies. They segregated confidential waste for secure destruction. 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. The pharmacy had a chaperone policy in place and displayed a notice telling people this. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough team members qualified and in-training to safely provide its services. The pharmacist and experienced team members adequately support those in-training to suitably complete their tasks. And these team members know how to seek guidance if required. The pharmacy provides learning and development opportunities to ensure team members have the knowledge and skills they need. They know how to make suggestions and raise concerns if they have any to help keep the pharmacy safe.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist, one full-time dispenser who had recently qualified and been appointed manager, one qualified and two trainee part-time team members and a part-time delivery driver. Within the past few weeks two experienced dispensers had left. One was full time and was the manager, and the other worked three days. Part-time team members were sometimes able to work extra hours to cover gaps. And a dispenser from another branch helped half a day per week, mainly assembling multi-compartment compliance packs. At the time of inspection there were two team members and the pharmacist working. They described managing the workload as challenging. Some days were more challenging than others due to the inexperience of team members. The previous day the computer had been down for a few hours which had negatively impacted dispensing. A dispenser and locum pharmacist had worked for an hour after the pharmacy closed to try and catch up with dispensing. This had helped but meant there were a lot of dispensed medicines for the pharmacist to check at the time of inspection.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. A recent training module was about Emla® cream. It provided team members undertaking accredited courses with additional time to complete coursework, and new team members to undertake induction training. The pharmacist supervised the inexperienced team members, coached them and responded to their questions. A team member described working slowly and asking lots of questions, but she was aware of the need for accuracy. Team members had annual development meetings with the pharmacy manager to identify their learning needs. They had development plans in place and objectives included improving dispensing knowledge and efficiency. Team members were observed going about their tasks in a systematic and professional manner. They sometimes asked appropriate questions when supplying medicines over the counter and referred to the pharmacist when required. But a team member sold a pharmacy medicine during the inspection with insufficient questioning or advice given. Team members demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They discussed case studies that they received from the pharmacy superintendent to learn from them. Team members made suggestions and raised concerns to the pharmacist, manager and area manager. They described asking for help when the pharmacy was particularly short-staffed. And a team member described raising a concern about a serious issue in the past, which was resolved. The team had regular monthly ‘Safer Care’ meetings. Team members kept notes of meetings and discussed a variety of topics including any themes or trends related to dispensing

errors, the age of people purchasing medicines and storing large bags of dispensed medicines on the floor. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for the services it provides. It has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed. But the dispensary is small for the volume of prescriptions dispensed.

Inspector's evidence

These were average-sized premises incorporating a spacious retail area, team area including storage space and staff facilities and a small dispensary which was cramped and cluttered due to restricted space. The dispensary became very congested when eight totes of medicines were delivered. The premises were clean, hygienic and well maintained. Team members followed a cleaning rota. There were sinks in the dispensary, staff area and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in a few locations.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, and computer which was clean and tidy, and the door closed providing privacy. This room was just large enough for social distancing which was managed by positioning chairs carefully. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and 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. All team members wore badges showing their name and role. The pharmacy provided a delivery service for dispensed medicines.

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. The pharmacy had limited dispensing space, and team members used it effectively to manage different types of dispensing. When there were two dispensers working, one worked on prescriptions from the surgery while the other worked on walk-in prescriptions and instalments. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy received quite a lot of 'phoned-in' prescriptions. Surgery team members provided the pharmacy with bar code numbers to enable it to supply medicines before receiving prescriptions. Pharmacy team members asked the surgery which prescriber had signed the prescription to try and get reassurance that the prescription was legal. The pharmacy usually received the prescriptions the following day. Many of these prescriptions were not urgent, and people often did not collect the medicines the same day. The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Previously when there were several experienced team members, medicines were packed the day before for delivery. This was not always possible now as sometimes dispensing was slightly behind and the delivery service was busier.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time. Previously when there were more experienced team members this had been done on set days one week before the first pack was due to be supplied. But currently due to fewer team members, with less experience, this process was being undertaken whenever possible, and sometimes the day before supply. Team members had raised this as a concern with the manager and area manager. Space was an issue, and this task could only be undertaken when there was an available dispensing bench. Team members followed a robust process and kept records of all changes and other information. They attached backing sheets firmly and they included tablet descriptions and date of supply. The pharmacy stored completed packs in labelled boxes in an orderly manner on dedicated shelves. And it supplied patient information leaflets with the first pack of each prescription. The pharmacy supplied four packs at a time to some people despite the prescriptions stating 'dispense weekly'. The team did not know if this had been authorised by prescribers. The pharmacy supplied a variety of medicines by instalment. A team member usually dispensed two weeks' or a few days' medicines at a time as there was not enough space to store more than that. And they dispensed some liquid instalments using a pump

device when people arrived at the pharmacy. 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 labelled shelves, or in secure cupboards depending on the medicine. A pharmacist supervised consumption of some medication in the consultation room. A team member cleaned it immediately after use.

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. It had undertaken a search for people in the 'at-risk' group. The pharmacy did not supply valproate to anyone in this group. Team members knew how to label valproate preparations and what information to supply. They had attached a reminder label to drawers containing this medicine. 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. And two new PGDs had just been introduced which the pharmacist was working through. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred most people to the pharmacist. 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 pharmacist delivered the NHS smoking cessation service to a few people. And she measured some people's blood pressure, including people who were prescribed an oral contraceptive. Often the condition of supply was that the person's blood pressure was measured and confirmed to be within defined limits. This was for private online prescribing and local NHS prescribing as prescribers were not seeing many people face-to-face. The pharmacy had recently started supplying lateral flow COVID tests to people requesting them. All team members were trained and competent to make the supplies and the associated administration.

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. But some shelves were untidy and congested due to too much stock or insufficient space. The pharmacist partially attributed this to inexperienced team members ordering items unnecessarily when they could not find them. 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.

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. Team members look after this equipment 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 which was maintained by the health board. And a blood pressure meter which was replaced as per the manufacturer's guidance. The team was not using some of this equipment during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped and ISO marked 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 test volumes each morning when they set it up to ensure it was accurate. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in locked cupboards in the consultation room and other areas 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.