General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 44A John Street, Penicuik, Midlothian, EH26 8AB

Pharmacy reference: 9011085

Type of pharmacy: Community

Date of inspection: 08/11/2021

Pharmacy context

This is a community pharmacy beside other shops including another pharmacy, in the town 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. It offers NHS and private seasonal flu vaccination and supplies lateral flow Covid tests. 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 help ensure they provide them safely. They record and review their mistakes to learn from them. And they make appropriate changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to by law, although it does not always audit records following best practice. Team members keep people's private information safe and 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 hand sanitiser available. The pharmacy had tape on the floor to encourage people to socially distance. It allowed three people on the premises at any time. People were observed queuing outside during the inspection. Most people coming to the pharmacy wore face coverings and team members all wore fluid resistant masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points daily. Team members had completed personal risk assessments early in the pandemic to identify any risk that may need to be mitigated in the pharmacy. One identified risk had been appropriately managed.

The pharmacy had standard operating procedures (SOPs) which the pharmacy team followed. Pharmacy team members had read them, and the pharmacy kept records of this. Staff roles and responsibilities were clarified on individual records. New team members had read and signed the SOPs relevant to their current role only. The pharmacy superintendent reviewed SOPs at least every two years and signed them off. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. And there was a clear process in place that all dispensing team members were aware of to enable an accuracy checking pharmacy technician (ACPT) to carryout final accuracy checks. 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. And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors to learn from them and they introduced strategies to minimise the chances of the same error happening again. Examples included separating strengths of co-codamol, forms of paracetamol and moving medicines from high shelves. This avoided team members having to stretch for these which risked them making selection errors. The pharmacy now used the top shelves for bulky items including dressings. The pharmacy also carried out professional standards audits and passed the most recent one five months ago. The team was behind with some internal Safer Care audits, but the manager explained that team members were aware of improvements required including tidying some areas.

The pharmacy had an indemnity insurance certificate, expiring 30 June 2022. The pharmacy displayed the responsible pharmacist notice and kept a 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. Team members had regularly audited these weekly as per the SOP prior to staffing challenges. But over the past few months they had not managed this regularly. And they had not been counting stock as they dispensed or replenished it. A recent audit had highlighted two discrepancies which were being investigated. The pharmacy had a CD destruction register for patient returned medicines.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP. 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 locally. 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 has enough experienced and team members in training to safely deliver its services. They are trained for their roles and provide services within their competence. Team members make decisions within their competence to provide safe services to people. They make suggestions and raise concerns to keep the pharmacy safe.

Inspector's evidence

The pharmacy had two part-time pharmacists, a full-time accuracy checking pharmacy technician (ACPT), a part-time dispenser, a full-time trainee dispenser/pharmacy manager, a part-time trainee dispenser, two part-time trainee medicines counter assistants and a delivery driver. The trainee medicines counter assistants had started a few weeks previously so were not yet registered on accredited training courses. They had read and signed SOPs relevant to their role. And the other team members were supporting their learning. One was observed undertaking tasks that she had been trained to do. The trainee dispensers were supported by the ACPT and pharmacist but undertook most of their training at home. One of the pharmacists was leaving imminently. Locum pharmacists were planned to cover her days. The pharmacy displayed certificates of qualification for the two qualified team members. Typically, there were three team members in the dispensary and one working on the medicines counter at most times, with less on Saturdays. Team members were able to manage the workload.

The pharmacy organisation had twice reviewed the team's hours. This had resulted in a reduction in hours. Some team members had left resulting in very low staffing levels at times. The team reported struggling to manage the workload during this time. This had improved over the past few weeks with the new team members in place. It was still difficult for team members to get time at work to undertake training and development. And there had been technical difficulty accessing training modules on the computer in the pharmacy. It had been several months since routine training was undertaken, but the manager was currently implementing this again. The pharmacist at the time of inspection had not yet undertaken training on new Patient Group Directions (PGDs) as part of the Pharmacy First Service. This was due to challenges getting time to undertake the training, and challenges delivering the additional services when the pharmacy was under pressure. The pharmacist had completed flu vaccination refresher training and was delivering this service. 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. Experienced team members worked autonomously within their competence. For example, they called the GP practice to remind GP colleagues to send ‘change forms’ as well as new prescriptions when they made changes to some people’s prescribed medication.

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 could make suggestions and raise concerns to the manager or area manager. The area manager had been supportive when team members raised concerns about staffing levels. He was a dispenser so had worked in the pharmacy at times. And he had arranged for an ACPT from another pharmacy to help. The area manager and pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. Team

members read this document and signed to acknowledge this. The pharmacy team discussed incidents and how to reduce risks. The pharmacy was part of a social media group to share information with other local pharmacies and surgeries. Information shared included challenges resulting in the pharmacy having to close over lunchtime and when there was any disruption to pharmacy services due to staff shortages. The company had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and suitable for the services the pharmacy provides.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and small rear area including storage space and staff facilities. Team members used the staff rest area for assembling multi-compartment compliance packs as they could work in that area with little distraction. They did not undertake this activity if a colleague was using the area for a rest break. The premises were clean, and well maintained, but cluttered in places. Team members cleaned surfaces each day. There were sinks in the dispensary, staff area and toilet. These had hot and cold running water, soap, and clean hand towels.

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 currently in frequent use for flu vaccination. Team members tried to observe social distancing by positioning of chairs. The door was kept locked to prevent unauthorised access. Temperature and lighting felt 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. 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.

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. When people requested their medication, pharmacy team members explained they would order the prescription and further explained what day the medicines could be collected. This was currently around a week and a half. People understood the timeframe and generally ordered in ample time. When the pharmacy received prescriptions a team member labelled them as soon as possible which created a stock order. The prescriptions were marked with the day of receipt, and the order was similarly labelled. So, when the stock arrived it could be dispensed without being put on shelves first. Team members explained that this was an efficient way of working and saved time compared with a previous way of working. Many people were still having remote phone or video consultations with GPs, so the pharmacy received acute prescriptions with standard repeat prescriptions. The GPs marked these prescriptions red, amber, or green depending on urgency. Red was highest priority, and the pharmacy undertook to dispense them the day they were received. GPs gave people a realistic time to collect their medicines from the pharmacy, considering the time that the pharmacy collected the prescriptions from the surgery and time for dispensing. This was working well. The pharmacy did not accept faxed or emailed prescriptions. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked dispensed medicines. And the pharmacist used a stamp and initialled prescriptions that she had clinically assessed to enable the ACPT to carry out the final accuracy check. Although the ACPT was not doing a lot of checking currently due to pressures on staffing. He was often dispensing so could not be involved in the check. He was checking for enough hours per month to satisfy the requirements of the checking qualification. The pharmacy sent some prescriptions for assembly at its off-site dispensing hub. People involved knew that their medicines were not assembled in this pharmacy. The pharmacist manged this process while carrying out clinical assessment of the prescriptions. A few people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these when people requested them. The pharmacist had no concerns about compliance. People were requesting their medicines as expected.

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, usually one week before the first pack was due to be supplied. They labelled them with instalment

numbers, dates of supply and tablet descriptions. And they supplied patient information leaflets with the first pack of each prescription. The pharmacy kept records of any changes and interventions. And team members encouraged prescribers to complete change forms rather than relying on phone conversations to request changes. The pharmacy made the changes as required, made a record of the change, and kept the forms. 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. Team members dispensed liquid medicines in separate bottles labelled with the date of consumption.

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 pharmacist had counselled them appropriately and checked that they were on a pregnancy-prevention programme. 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), chlamydia treatment and flu vaccination. It also followed private PGDs for flu vaccination. The pharmacy team members referred requests for the Pharmacy First service to the pharmacist. They completed a template with the person's details and symptoms to assist the pharmacist. Due to recent challenges in the pharmacy, the team was not delivering services including smoking cessation. But the pharmacist was busy with flu vaccinations. People booked appointments online and most days were busy. Some team members had been trained to conduct the first part of the consultation and complete the paperwork with the person. The pharmacist checked that all answers were appropriate then administered the injection. This worked well and minimised the impact on dispensing by the pharmacist's repeated absence from the dispensary.

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 medicines, and obsolete items. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. These were observed to be within accepted limits. Team members checked expiry dates of medicines and those inspected were found to be in date. As with other tasks this had not been done regularly over the past few months, but the team had recently started again. A basket of date expired items was observed. 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. And 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. But the team was not using this equipment during the pandemic to reduce the chance of spreading infection. Team members kept ISO marked and crown-stamped measures by the sink in the dispensary, and separate marked ones were used for methadone. The pharmacy used an automated pump for measuring methadone solution. Team members cleaned it at the end of each day and poured test volumes each morning. The pharmacy team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in a locked cupboard in the consultation room and in the dispensary 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.