General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 6 Macmillan Square, Edinburgh, EH4 4AB

Pharmacy reference: 9011173

Type of pharmacy: Community

Date of inspection: 22/01/2020

Pharmacy context

This is a community pharmacy close to a GP practice in a residential area. 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.

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 team members follow written processes for all services to ensure that they are safe. They record mistakes to learn from them. And they make changes to avoid the same mistakes happening again. The pharmacy keeps all the records that it needs to. And it keeps people's information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. They read new ones as they were received. A recent one had related to controlled drugs. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and the pharmacy kept records of competency for each team member. 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, in a methodical manner. It 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. But they did not always record these, particularly when they were busy. Team members had noted reasons for errors as being busy, being distracted, not double checking, and working on two prescriptions at the same time. They also recorded errors reaching patients to learn from them. They usually reviewed all near misses and errors each month but recently this had been challenging as they were busy. And the regular pharmacist had left a few weeks previously. The pharmacy had introduced some strategies to minimise the risk of the same error happening again. It had separated olanzapine and omeprazole, and amlodipine and amitriptyline following instruction from head office. The pharmacy usually carried out 'safer care' audits weekly, although these had not been done over the past few weeks. Team members had planned these for the current week, but staff absence had prevented it. They had last updated their safer care board the previous month, and they last recorded a briefing meeting two months previously. A team member had noted at that time that date checking was behind, and this was still the case at the time of inspection. The pharmacy displayed a guidance note dated two months previously in the dispensary. It covered topics such as the valproate pregnancy prevention programme, controlled drug (CD) discrepancy reporting and safeguarding.

The pharmacy had a complaints procedure that team members were aware of. The pharmacy had an indemnity insurance certificate, expiring 31 June 20. It 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.

The pharmacy had last audited methadone solutions on 30 December, and they had been correct. But by 17 January the running balance of the 'original' solution was incorrect and showing a negative figure. A dispenser audited the running balance of sugar-free methadone, but the pharmacist who had left

usually audited the sugar containing solution. A locum pharmacist was investigating this during the inspection. He knew to report it internally and to the NHS CD accountable officer.

Pharmacy team members were aware of the need for confidentiality. They had all read a SOP and undertook training annually. They segregated confidential waste for secure destruction. And they stored bags containing confidential waste in the toilet area. There were a lot of bags waiting to be uplifted. No person identifiable information was visible to the public. Team members used the phone carefully to avoid being overheard. This was difficult as they only had a mobile phone and the signal was poor in the pharmacy. Team members had also undertaken training on safeguarding. They knew how to raise a concern. The pharmacy had a chaperone policy in place and displayed a notice telling people. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide services. Team members can share information and raise concerns to keep the pharmacy safe. The pharmacy addresses concerns raised appropriately.

Inspector's evidence

The previous pharmacist had left around a month before. Currently locum pharmacists working two weeks at a time were covering. And additional locum pharmacists provided double cover one or two days per week. At the time of inspection, there were two locum pharmacists, one from London and the other from Aberdeen. There were times when one of the pharmacists had nothing to do if there was no dispensing for checking. They were not aware of routine tasks to be undertaken.

The pharmacy had the following staff: an accuracy checking technician (ACT) one day per week; a relief dispenser one day per week covering some annual leave (present during the inspection); five part-time dispensers - one was on annual leave and one was off sick at the time of inspection; one part-time and one full-time medicines counter assistant (supervisor), and a part-time delivery driver. Typically, there were four or five team members working at most times. At the time of inspection there were three dispensers (one was relief), the supervisor and the two locum pharmacists. Saturdays could be challenging as there was often only one team member and the pharmacist in the afternoon. The ACT checked instalments and multi-compartment compliance packs, so team members ensured these were assembled ready for her to check. One dispenser was acting manager, so was learning this role. And this was taking her away from her usual dispensing time. Team members were able to manage the workload, but a lack of continuity and absence were making this difficult. They were not keeping up with some routine tasks such as date checking, safer care audits, investigating a controlled drug discrepancy, removing items from retrieval shelves, and training and development. The pharmacy was busier than it had been a few months' previously. It had relocated about six months ago and was closer to the GP practice and beside a dental practice now. So, more people were walking past and increasing foot-fall. Team members were experienced and had worked together in this pharmacy for several years. They had established routines and supported each other. Some part-time team members had scope to work flexibly providing contingency for absence.

The pharmacy team members did not have regular training or development. But they took time to read safer care documents. And they had used 'learning zone' documents several months previously. 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 awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The medicines counter assistant/supervisor explained that people did not often request repeat supplies of these products.

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. But as noted above they did not always record them when they were busy. They could make suggestions and raise concerns to the manager or area manager. They described an example of raising a concern about the supply of dispensing sundries and bottles with the area manager. He arranged supplies from other pharmacies. Team members had also raised concern about

the phone situation described elsewhere. Head office personnel were working to try and resolve this. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members described trying to meet these by signing people up to services that they would benefit from.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services. The pharmacy team members use private areas for some discussions with people. Other people cannot hear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were modern premises incorporating a retail area, dispensary and back shop area. The premises had very little storage space which resulted in a cluttered appearance. One of the staff toilet areas had several boxes of obsolete stock and sealed bags of confidential waste stored in it. The dispensary was also cluttered with some bags of dispensed medicine stored on the floor as there was not enough shelving. The premises were well maintained but some areas were not particularly clean e.g. staff toilet and sink, the floor in the dispensary where methadone was poured, and the shelf in the supervision room which had methadone spills on it. There were sinks in the dispensary, staff room 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. The pharmacy also had a separate area for specialist services such as substance misuse supervision. It had doors from the retail area which gave a degree of privacy. And it had a hatch to the dispensary. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure that they could use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team knows 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. The pharmacy signposted people to other services such as needle exchange. 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.

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. They worked in three distinct areas: they managed the walk-in and most of the collection service prescriptions on a dispensing bench to the front of the dispensary and close to the checking area; they managed multicompartment compliance packs on a bench to the rear of the dispensary; and they managed instalments on a separate area to the rear of the dispensary. Team members were very clear which activity they were undertaking, with individuals having ownership for the management of multi-compartment compliance packs, and instalment dispensing. But all team members were competent to undertake all tasks. Team members highlighted any changes or new items on prescriptions to the pharmacist who looked at the patient medication record to undertake a clinical assessment. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacist initialled prescriptions to provide an audit trail of clinical checks. This enabled an accuracy checking technician (ACT) to carry out the final accuracy check on these items. Team members contacted people by text message to remind them to collect their medicines if they had been on retrieval shelves for two weeks. They sent a further text after another two weeks. Then they removed the medicines from shelves and endorsed prescriptions accordingly.

The pharmacy usually assembled owings later the same day or the following day using a documented owings system. Some people received medicines from chronic medication service (CMS) serial prescriptions. But team members working at the time of inspection did not know how this process was managed. One team member had ownership of this and was on annual leave. The pharmacy kept records on the computer so if necessary, a team member would use this to determine if prescriptions were due to be dispensed.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time. Team members usually assembled packs a week before the first one was required. But currently they were only a few days ahead of supply. A team member explained that they had not been able to catch up since the Christmas holiday period due to staff absence. A team member was assembling a pack during the inspection that was due for supply that day. She explained that the previous week prescriptions had been misplaced and she had been waiting for replacements. Team members followed a robust process and kept thorough records. The pharmacist or ACT undertaking the final accuracy check sealed the packs. The team member assembling the packs left original packaging to

facilitate the accuracy check. Team members placed controlled drugs into packs on the day of supply, then stored these in a CD cabinet. There was not enough space in the cabinets for these to be made up in advance. Team members marked the front and the spine of packs with the start date and personal details. They attached backing sheets firmly to packs and these also had start dates and tablet descriptions on them. They supplied patient information leaflets with the first pack of each prescription. The pharmacy stored completed packs in individual named boxes on shelves in the dispensary. Team members turned boxes round and attached a note when people were in hospital. The pharmacy supplied a variety of other medicines by instalment to a lot of people. Team members managed this process well and filed prescriptions in two different locations depending whether people also received methadone or buprenorphine with other instalments. One team member had ownership for this although others could deputise. She assembled instalments a few days in advance and stored them in baskets which were labelled by day 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. She/he 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 and one in this group was supplied with valproate. 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, and chlamydia treatment. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under a pharmacist's supervision. 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 pharmacy had offered seasonal flu vaccination until the previous month when the regular pharmacist had left. Two experienced team members were trained and able to measure blood pressure and test for diabetes. But this service was no longer requested.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not comply with the requirements of the Falsified Medicines Directive (FMD). It had the equipment on site, but team members believed it was not yet functioning. They had not received any training yet. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. But it had some loose tablets in bottles which were not properly labelled. And team members were pouring methadone solution from 500ml bottles to 2.5L containers for use in the 'methameasure' pump device. They were not labelling the 2.5L container with the correct contents' information. They 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 they had missed some days. Team members regularly checked expiry dates, although they had not done this for several weeks. Items 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 MHRA recalls and alerts on receipt and kept records. It had some information on the safer care board about recalled items e.g. ranitidine tablets. 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. It looks after this equipment to ensure it works. And team members use it appropriately. They raise concerns when equipment is not fit for purpose. And the pharmacy acts in a positive way.

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. It did not have a land-line phone, so team members used a mobile phone. But the signal in the pharmacy was very variable. This was observed to be difficult as the strongest and most reliable signal was close to the medicines counter. Team members demonstrated awareness, and spoke as quietly as they could, with their backs to the front-shop, to minimise the chance of conversations being overheard. Sometimes they took calls in the consultation room. For this reason, the pharmacy did not promote this phone number. Team members only gave it to other healthcare professionals. This meant the public could not phone the pharmacy for advice.

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 which had been obtained recently, and blood testing equipment calibrated as per guidance. The pharmacy did not use this equipment often. It also had items required for infection control e.g. wipes, gloves and sharps boxes in a cupboard in the consultation room. 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 had a ‘methameasure’ pump available for methadone use. A team member cleaned it at the end of each day and poured test volumes each morning. Recently team members had identified that it was not pouring accurately. So, they reported this to the manufacturer who re-calibrated it. At the time of inspection, the finger-print recognition equipment was not in use as it was not working. Team members did not know if this had been reported. They were asking people for their date of birth and using photographs for identification. 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 the dispensary 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.