

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 18 High Street, KIRKCALDY, Fife,
KY1 1LU

Pharmacy reference: 1042104

Type of pharmacy: Community

Date of inspection: 31/01/2020

Pharmacy context

This pharmacy is within a town centre. It dispenses NHS and private prescriptions. It provides NHS services such as supervised methadone consumption. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartment compliance packs. These help people remember to take their medicines. It delivers medicines to people's homes and offers a range of over-the-counter medicines.

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	1.2	Good practice	The pharmacy team regularly and comprehensively reviews near miss errors and other patient safety incidents. They keep records of what they learn and how they improve the safety and quality of the services.
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 has written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The team members responsibly discuss mistakes they make during dispensing. They consistently record and learn from these. The pharmacy keeps all the records as required, by law in compliance with standards and procedures. It provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which the pharmacy team members have read. They had all signed and dated revised versions in November and December 2019. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as dispensing of prescriptions and controlled drug (CD) management. The team members could advise of their roles and what tasks they could do. They advised as a small team they all shared all tasks. The team received a company daily update 'Daily Dose' which provided and alerted them to any matters requiring attention and general information. There were also several other audits undertaken by the company to manage the running of the pharmacy.

The pharmacy had two computer terminals. The team members used one for the main dispensing. And they used the other for preparing labels for methadone and repeat prescriptions. The dispensary was small but well managed. The team utilised the limited space well. The dispenser advised that once they had completed the repeat prescriptions from the surgery for the day, they used the bench area for preparing the compliance packs. They slotted in the preparation of the compliance packs into the general workload. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used red baskets for people waiting in the pharmacy, white for people calling back and grey and blue for all others. This distinguished people's prescriptions by degree of urgency, and this helped plan workload.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team members recorded these on a specific template. They were an experienced team and worked to a robust process. They had few near miss errors. But actively recorded. And recorded if there were any days with no errors. They were scanning stock as part of the dispensing to produce labels for prescriptions. This had reduced selection errors. They double checked the stock with the label and prescription. The team members recorded their own near miss errors when the pharmacist pointed them out. Examples included salbutamol 100mg dry powder instead of the easy haler. And the recorder had noted that most of the inhalers were for the cfc free which had led to them selecting the wrong one. They had discussed this as a team and recorded it in the briefing to prevent future errors. They had noted yaltormin 1000mg, with 500mg dispensed in error. And completed comments stating 500mg being the most common strength to dispense. And another factor identified was that one dispenser was on holiday, so they were busy. They had also noted they had dispensed the wrong form for lansoprazole. The team members had adopted the new company process for checks for the Look-Alike Sound-Alike (LASA) drugs. They had removed any from the top 30 location. And they were stamping prescriptions with the stamp which stated LASA and had a box for the dispenser to initial and for the

checker to initial. They were also placing the LASA drug into a clear bag with a label LASA which served as a reminder during the dispensing process. The pharmacy displayed the safer care white board. And they had updated it with a note to take care when selecting simvastatin and lisinopril as the team had noticed the boxes looked very similar. The team members had briefings and they all signed the attendance record. They discussed tasks that needed to be done. This had included planning completion of the compliance pack dispensing and methadone supplies to ensure they were ready for Christmas. This helped them plan workload with time. And this reduced some pressure in the pharmacy. The team members discussed and learnt from case studies sent by the company.

The pharmacy had a practice leaflet and a notice displayed in the pharmacy which explained the complaints process. The pharmacy had a folder with the Lloyds complaints process. And the NHS Scotland copy for reference. There was a procedure to record and report dispensing errors and the team followed this procedure. They learnt from errors and completed reflective statements to look at ways improve for the future. They had discussed split packs and ways to improve the dispensing from these to reduce any errors. They also noted that they had re-read relevant SOPs. The pharmacy had current indemnity insurance in place.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records on the computer as required. The team advised the pharmacists stayed in over lunchtime. But they all knew what they could and could not do if the pharmacist left the pharmacy. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy usually checked CD stock against the balance in the register after each dispensing. This helped to spot errors such as missed entries. These were complete with running balances maintained. And the register indicated weekly stock audits were undertaken. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it generally destroyed items on the day people returned them. So, this did not allow a build-up in the CD cabinet. They did not receive many CD patient returns. The pharmacy kept special records for unlicensed products with the certificates of conformity completed. It kept records for private prescriptions and had a few prescriptions received through the Lloyds online service. And a few veterinary prescriptions with the cascade declaration.

The pharmacy displayed a privacy notice at the counter with information on the confidential data kept and how it complied with legislation. The team had completed training on Information Governance thought e-Learning which covered the General Data Protection Regulation (GDPR). The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy team stored confidential waste in separate bags for offsite shredding. The pharmacy had a safeguarding policy and procedure for the protection of vulnerable adults and children. The pharmacist was PVG (Protecting Vulnerable Groups) registered. And had undertaken training through NHS Education Scotland (NES) on safeguarding. The pharmacy had local safeguarding organisation details available but advised they would follow the company process. And contact the SI office in the first instance.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. It provides team members with access to ongoing training. This helps them have the skills and qualifications they need for their role. The team members understand their roles and responsibilities in providing services. And they support each other well in their day-to-day work. They feel comfortable raising any concerns they may have.

Inspector's evidence

There was one pharmacist and two dispensers working in the pharmacy. In addition, there were another dispenser and a technician. The technician worked 36.5 hours a week and was the supervisor. She was currently assisting at another branch nearby. And did so regularly. One of the dispensers at this branch worked 12 hours a week but had increased to around 25 hours to help cover the supervisor's absence. The dispensers worked between 12 and 32 hours a week. The pharmacy did not receive additional staff when people were on holiday or had days off which meant it was challenging during these periods. The team were all experienced with the exception of one newer member. And they worked well together and helped each other with tasks. On Saturdays there was a pharmacist and one team member present. It was generally quieter on this day.

The pharmacy team members had training records. And undertook training on the company system My Knowledge. They advised they received training every month. The last training was on CBD oil. They also undertook training on MyLearning. This included safeguarding, sepsis and LASA drugs. The team members said they just had to make time to get the training done but it was hard to fit it in. They were all on track with required training. The pharmacist advised that they attended NHS Education Scotland training events. And completed NES training modules. Recent topics included sodium valproate, non-steroidal anti-inflammatory drugs (NSAIDs) and quality improvement. The team received performance reviews which gave the chance to receive feedback and discuss development needs.

The dispensers followed the sales of medicines protocol when making over-the-counter (OTC) recommendations. And asked the pharmacist to intervene if required. The dispensary team worked closely together and assisted each other in all tasks. Being a small team, they all did everything. They planned ahead for holidays and absences to ensure tasks were completed in time. There was a formal whistle blowing procedure and telephone numbers were available so the team members could easily and confidentially raise any concerns outside the pharmacy if needed. The company had targets for various parameters. The team members felt the targets set were achievable and were set for services that could benefit people. This included asking people to sign up to receive text messages when their prescriptions were ready for collection.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And it has facilities where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean, tidy and hygienic and fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The dispensary was compact but well organised. And the team used the limited space in an organised way. The sinks, benches, shelves and flooring were all clean and the team completed a cleaning rota to ensure they maintained the required tasks. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. They put away orders promptly. And stacked empty tote boxes, for return, neatly to take up minimum space. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a good sized, signposted, sound proofed consultation room which the team promoted for use. There was a notice at the entrance to the consultation room about the chaperone policy asking patients if they would like a family member or chaperone present. The pharmacy team members kept the consultation room locked when not in use. The team assisted people as they entered the pharmacy, with a member of the team generally covering the counter. People could not access the dispensary due to the layout of the counter.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy is accessible to people. The pharmacy provides its services using a range of safe working practices. The pharmacy team members take steps to identify people taking some high-risk medicines. And they provide people with additional advice and support. They dispense medicines into compliance packs to help people remember to take them correctly. And they manage this service well. The pharmacy gets its medicines from reputable suppliers. It adheres to storage requirements during the dispensing process. It takes the right action if it receives any alerts that a medicine is no longer safe to use.

Inspector's evidence

The pharmacy had good access by means of a level entrance and automatic door. There was some customer seating. And a working hearing loop in place. The team members wore name badges with their role. The pharmacy displayed its services in the window and within the pharmacy. The hours of opening were on the door. The pharmacy had a practice leaflet and a range of leaflets and posters with health care information. The pharmacy had a defined professional area. And items for sale were mostly healthcare related. The sections specified the type of items sold such as skin care and pain relief. The pharmacy kept the pharmacy medicines on the shelves with Perspex covers. The covers clearly stated on the front 'please ask for assistance'. And team members helped people wishing to purchase these items.

The pharmacy received some medicines from the chronic medication service (CMS) on serial prescriptions. The team members reviewed these prescriptions. And they asked people if they still required everything to try to avoid over ordering and waste. All of the team undertook blood pressure readings and carried out blood glucose tests. The pharmacist provided smoking cessation, with two people using the service. And two more new starters. The pharmacy provided emergency hormonal contraception (EHC) through the patient group direction (PGD) and undertook the electronic minor ailments service (eMAS). The eMAS was popular for treatments for head lice and worms. The team members delivered the service 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 provided unscheduled care and the gluten free service and followed the procedure for these. It provided treatment for urinary tract infections through the Pharmacy First scheme. This was well used with the doctors referring people to the pharmacy. It also received a few people coming for treatment for impetigo under the scheme.

The pharmacy supplied medicines to around 45 people in multi-compartment compliance packs to help them take their medicines. The doctors assessed people who wanted their medicines supplied in compliance packs. And then supplied the appropriate prescriptions to the pharmacy. One of the dispensers managed the process. And had a good tracking process in place. She ordered prescriptions for the next set of compliance packs when the pharmacy supplied the third pack of the previous cycle. This allowed plenty of time to obtain prescriptions. And allowed time to plan workload if there were any delays or if staff were absent or going on holiday. The pharmacy supplied patient information leaflets (PILs) with the packs, once with each cycle. The tracker showed which packs the pharmacy delivered, or people collected. And when it had supplied them. The tracker showed if people received any items such

as pregabalin or other CDs. The pharmacy provided a second separate pack to people if they received CDs which allowed the team to prepare the packs ready for supply. The pharmacy stored packs with CD requiring safe custody in the CD cabinet. This worked well and was manageable. Each person had a profile sheet and the team clearly documented any changes to their medicines. And kept discharge notes and other information with the profile sheet. The team recorded descriptions of medicines on the backing sheets and completed the audit trails of who had dispensed and checked the packs. The pharmacy stored the packs in boxes labelled for individuals on higher shelves round the dispensary with the profile sheets kept in the box for reference.

The pharmacy offered a substance misuse service for methadone and buprenorphine. One of the dispensers poured the methadone using a pump generally twice a week. And the pharmacist checked the amounts. This ensured supplies were ready for people. The dispenser was preparing ahead as one of the team was going to be on holiday the following week so this would assist with the workload during her absence. This facilitated timely hand-out when people attended. Most people received daily supervised doses or took two to three days away.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The team used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so the contents could be checked again, at the point of hand-out. The pharmacist counselled people on high-risk medicines and the team placed alert stickers to raise awareness at the point of supply. The team members used CD and fridge stickers on bags and prescriptions to prompt the person handing the medication over that they required some medication to complete the supply. The CD stickers recorded whether the CD was in the bag or in the CD cabinet. When the pharmacy could not provide the product or quantity prescribed in full, patients received an owing slip. And the pharmacy kept a copy with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable to ask for an alternative.

The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. The pharmacy had undertaken a search for people on this medication. The team had identified one person, but they were not in the at-risk group. The team members explained the information they would provide to the 'patients in the at-risk' group. And had alerts stickers and patient guides in a folder. The pharmacy provided a repeat prescription collection service. It displayed a notice on the counter which advised people when their medicines would be ready from the date, they ordered them. The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. People signed the driver's pod when they received their medication. And they signed a separate delivery sheet for controlled drugs.

The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf prior to the expiry date. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use.

The pharmacy used recognised wholesalers such as AAH and Alliance. The team were aware of the

Falsified Medicines Directive (FMD). And that the company were undertaking some trials. But were not sure when the pharmacy would implement the process. The team used appropriate medicinal waste bins for patient returned medication. The contents of the bins were securely disposed of via the waste management contractor. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. The team members actioned these and kept records of the action taken. They included these on their monthly briefings.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways to protect people's confidentiality.

Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It used a pump for measuring methadone. The team poured stock bottles into the five-litre container and attached the pump. Then made up supplies. If there was any residual amount left the team poured this back into the original container the stock had come out of. The dispenser left all the stock bottles together until they had poured all the methadone. The dispenser then washed the pump and container ready for the next time. The dispenser checked the batch numbers were the same for the bottles used. The pharmacy kept some measures marked for measuring methadone for calibration and for interim supplies of necessary. It also had a range of equipment for counting loose tablets and capsules. The team members cleaned triangles after use.

The team members had access to disposable gloves and alcohol hand washing gel. An external organisation checked the carbon monoxide monitor. And the team checked the blood pressure machine and the pharmacy replaced it when required. The team members checked the glucose monitor and they calibrated it regularly to make sure it was providing accurate readings.

The pharmacy stored medication waiting collection on shelves in the dispensary where people could not see any confidential details. The team filed prescriptions in boxes in a retrieval system out of view, keeping details private. The computer in the consultation room was screen locked when not in use. The computer screens in the dispensary were out of view of the public. The team used cordless phones for private conversations.

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.