

Registered pharmacy inspection report

Pharmacy Name: Lloyds pharmacy, 286 High Street, LINLITHGOW,
West Lothian, EH49 7ER

Pharmacy reference: 1043062

Type of pharmacy: Community

Date of inspection: 14/08/2020

Pharmacy context

This is a busy community pharmacy beside a health centre. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. It sells a range of over-the-counter medicines, offers flu vaccination during the flu season, offers the NHS smoking cessation service and provides substance misuse services including needle exchange.

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 team members follow written processes for all 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 that it needs to by law and keeps people's private information safe. Team members help to protect 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 tape on the floor to encourage people to socially distance. It allowed two 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 masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces first thing in the morning, last thing in the afternoon and 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.

The pharmacy had standard operating procedures (SOPs) which had recently been reviewed. Team members were in the process of reading and signing the new versions. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. Some team members had ownership of certain tasks including the management of multicompartiment compliance packs and instalment prescriptions. But all tasks and activities could be undertaken by several team members. The pharmacy managed dispensing, the pharmacy's main 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. They also recorded errors that had been identified after people had received their medicines to learn from them. They reviewed all near misses and errors each month and introduced strategies to reduce the chance of the same error happening again. Recently, recurring incidents included incorrect strengths and the wrong form (tablets or capsules) being dispensed. This was documented in the 'safer care' briefing notes which all team members read, and on a white board in the staff area. Team members had separated some items involved in mistakes, and used shelf edge labels to identify others. A team member undertook safer care audits each week as dictated by head office. These identified areas where improvements could be made. Recently this had resulted in a team member tidying the fridges and some drawers. The pharmacy had managed to complete these audits each week throughout the pandemic. The pharmacy manager explained that all team members were being encouraged to take a turn at undertaking these audits.

The pharmacy had a complaints procedure and welcomed feedback. It had followed this procedure when it had received two complaints a few months previously. The pharmacy team had worked hard since the last inspection improving services and tidying drawers. This was reflected in recent positive customer reviews on social media.

The pharmacy displayed an indemnity insurance certificate, expiring 30 April 21. It also displayed the responsible pharmacist notice and accurately 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.

Pharmacy team members were aware of the need for confidentiality. They had all undertaken a training module which was repeated annually. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also undertaken training on safeguarding. They knew how to raise a concern and to notify head office. The pharmacy displayed its chaperone policy and privacy notice. Team members described examples of raising concerns with prescribers and key workers about vulnerable people. This had resulted in changed doses and dose titration for some people.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified or team members in training to safely provide its services. They have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training during the working day. Team members make decisions appropriate to their role and use their professional judgement to help people. They can share information and make suggestions to improve ways of working and keep the pharmacy safe. And they know how to raise concerns if they have any.

Inspector's evidence

The pharmacy had the following staff: two part-time pharmacists, one full-time manager/dispenser, one full-time and four part-time dispensers, two part-time trainee medicines counter assistants, and a part-time delivery driver. The pharmacy displayed their certificates of qualification. Typically, there were three or four team members in addition to the pharmacist working at most times. Team members were able to manage the workload. Part-time team members had some scope to work flexibly providing contingency for absence. One of the pharmacists was on the provisional register because there had been no formal assessment this year due to the COVID-19 pandemic. He explained that a risk assessment was undertaken before he started and he was well supported by a senior pharmacist with planned monthly meetings. He was working part-time to ensure he had adequate time to prepare for the registration assessment. Two dispensers were leaving over the next few weeks and they were not being replaced.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development including reading the new versions of the SOPs. Recent topics included weight-loss and cannabidiol (CBD). Team members were observed going about their tasks in a systematic and professional manner. They communicated clearly and effectively when speaking to people on the phone. And they were empowered and able to solve problems. For example, a dispenser contacted the GP practice when she identified that a prescription was missing. She then contacted the patient to explain the situation and confirm when medicines would be available to collect from the pharmacy. Team members 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.

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. The pharmacy manager used a whiteboard in the staff area to share information with all team members. They discussed incidents and how to reduce risks each month when the safer care audits had been completed. Team members explained that they could make suggestions and raise concerns to the manager or area manager. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members described using these as a reminder to offer people services that they would benefit from.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are clean, and suitable for the pharmacy's services. The pharmacy team respects and manages people's confidentiality.

Inspector's evidence

These were average-sized premises incorporating a retail area, dispensary and back-shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. Team members cleaned surfaces frequently during the day and this was observed during the inspection. They had disinfectant sprays in several locations. 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 and computer which was clean and tidy, and the door closed providing privacy. It had a hatch through to the dispensary. Team members were not using this room frequently due to the risk of COVID-19 infection. They were able to speak to people discreetly in the retail area of the premises when there was no one else in the pharmacy. Temperature and lighting were comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy helps people to access its services and it provides its services safely. Team members support people by providing them with information and advice to help them use their medicines. And they provide extra written information to people taking higher risk medicines to help them take them safely. The pharmacy obtains medicines from reliable sources and stores them properly. The 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 ramp at the entrance and an automatic door. It listed its services and had leaflets available on a variety of topics including the new NHS Pharmacy First service. 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 which had been busier than usual over the past few months as some people were shielding or preferred not to come to the pharmacy because of the COVID-19 pandemic. The driver had managed well throughout this time. She used PPE and always maintained a social distance. She described how she assisted people that were unable to pick their medicines up from the doorstep.

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 team had reviewed how it worked and made some changes to enable social distancing. Team members worked at different workstations to maintain some distance from each other and manage walk-in and collection service prescriptions in different areas. They had devised a bespoke form to capture relevant information required for ordering repeat prescriptions. And these forms were kept beside phone. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these before people came to the pharmacy and there was no evidence of non-compliance. Team members had recently implemented a new system for removing uncollected medicines from the shelves after four weeks and contacting people. Usually these medicines were owings, but the pharmacy informed the GP practice if they were full prescriptions that had been uncollected.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time, at least a week before the first pack was due for supply. One team member had ownership for this process and several others were competent to deputise. They kept thorough records of medicines' changes and other clinical information. And they recorded when packs had been supplied. Completed packs were stored in individual boxes labelled with patient details on labelled shelves. Team members attached backing sheets firmly to packaging and included descriptions of medicines in the pack. They supplied patient information leaflets with the first pack of each prescription. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when they were received. They stored each instalment in a labelled bag within a labelled basket per patient. A 'Methameasure' pump device was used to dispense methadone when people

presented at the pharmacy. When the pharmacy received prescriptions, a team member put the instalment regime on the 'Methameasure' computer, and the pharmacist checked this. When people presented to the pharmacy a team member used photographic identification, asked them for their personal details and what dose they were expecting. A dispensing team member dispensed methadone into a bottle which was checked by a pharmacist. Takeaway doses were dispensed into individual bottles for each day. To reduce the chance of spreading infection, team members placed instalments into a basket which they presented towards the person through the hatch into the consultation room. The person removed the instalment from the basket and self-administered the medicine. People placed their used bottles straight into a waste receptacle in the consultation room for infection control. The pharmacy had continued supervising methadone consumption throughout the pandemic. The team had devised this way of working to maintain social distance and avoid handling bottles after other people. Team members also provided the needle exchange service through this hatch.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. The person received 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 had ordered a replacement pack of material to supply to people. 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 new Pharmacy First service (eMAS) 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 to the pharmacist as required.

The pharmacists provided the NHS smoking cessation service, but this was not busy currently. Team members were not taking carbon monoxide readings from people as this could be an infection risk. They were not offering the diabetes testing service for the same reason. Typically, these services were not in great demand in this pharmacy.

The pharmacy obtained medicines from licensed wholesalers such as Alliance and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). Team members had undertaken training several months before. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in three fridges and team members monitored minimum and maximum temperatures. 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 sale of medicines protocol was on the wall close to the medicines counter for team members to refer to.

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 for the delivery of its services. The pharmacy looks after this equipment to ensure it works.

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.

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 was replaced as per the manufacturer's guidance, and blood testing equipment calibrated as per guidance. Records of this were observed, although not for a few months as this service was not currently being offered due to the COVID-19 pandemic. The pharmacy had the PPE it required. And it had masks that it could supply to people on request if they arrived in the pharmacy without a face covering. During the inspection a team member provided a mask to a person who was going to the GP practice. People were not allowed into the practice without face coverings. 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 pump available for methadone use and this was cleaned, and test volumes poured daily. 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 a locked filing cabinet 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 people in the retail area. 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.