

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 49-51 High Street, TRANENT, East Lothian, EH33 1LN

Pharmacy reference: 1093097

Type of pharmacy: Community

Date of inspection: 08/04/2019

Pharmacy context

This is a high street pharmacy in a town serving a mixed community. The area is growing due to new homes being built. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also supplies medicines in multi-compartmental medicine devices. Other services the pharmacy offers include chronic medication service (CMS), minor ailments service (eMAS), travel vaccination, flu vaccination during the flu season and health checks such as blood pressure and diabetes.

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	1.3	Good practice	Pharmacy team members have clearly defined roles. They can all do all tasks, and take turns on each task.
		1.4	Good practice	The pharmacy welcomes feedback. And this is discussed and services improved as a result.
2. Staff	Standards met	2.4	Good practice	Pharmacy team members discuss incidents, own up to mistakes, and make changes to improve pharmacy services.
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

Pharmacy team members follow processes for all services to ensure that they are safe. They record mistakes to learn from them. They review these and make changes to avoid the same mistake happening again. The pharmacy asks people for feedback. Pharmacy team members discuss this to make pharmacy services better. The pharmacy keeps all the records that it needs to by law. And keeps people's information safe. Pharmacy team members help to protect vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were in place and followed for all activities and tasks. These had been read by relevant staff members. Staff competence sheets were signed, clarifying which SOPs each team member was competent in. They were reviewed every two years and were signed off by the pharmacy superintendent.

The team members described high risk activities such as different dispensing processes, including methadone supply and the supply of medicines in multi-compartmental compliance packs. Risks were managed by team members rotating through tasks to avoid doing the same all day. All team members were competent to do everything.

The pharmacy had a list on the dispensary wall of daily and weekly tasks e.g. recording fridge temperature, checking and printing emails, putting delivery stock away, dispensing balances, filing paperwork and ordering stock. Team member's names were recorded against each task and they signed and dated as they undertook these. Dispensing was done in a logical way, with coloured baskets in use to keep items together.

An accuracy checking technician (ACT) checked dispensed medicines after they had been clinically checked by a pharmacist. She knew this had been done because the pharmacist stamped and signed prescriptions after clinically checking. The ACT kept a log of all her checking time. She had a very organised filing system for all her accuracy checking.

There was an audit trail in place for dispensed medicines in the form of dispensed and checked by signatures on labels. Business continuity planning was in place to address maintenance issues or disruption to services. The pharmacy displayed a contact phone number for all issues.

Near miss logs were kept and error reporting was in place. The pharmacy did not record near misses on days that locum pharmacists were working. The near misses were reviewed monthly in turn, by either the safer care champion, who was the ACT or a dispenser. The main trend identified recently was dispensing incorrect quantities. This was attributed to packaging not being appropriately marked when it was partially used. All team members had been reminded to score open packs on all sides to identify them. Weekly audits were undertaken and records kept of these to ensure that all processes were followed as they should be.

Staff members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. There was clarity regarding the role of different staff roles e.g. the ACT and manager. The pharmacy had a complaints procedure in place that team members were

aware of. Feedback was welcomed and encouraged from people, and some reflection and changes were described. The pharmacy team members described examples of responding to feedback. They had not always had prescription medicines ready for people as expected. This included medicines supplied by instalment. Team members reflected on how they could improve this and changed their process so that instalments were dispensed immediately after the one before had been collected. Team members described another example of changing the process following an incident regarding the supply of a multi-compartmental compliance pack. People now signed for their medicine when they collected it.

The pharmacy displayed an indemnity insurance certificate expiring June 2019.

The following records were maintained in compliance with relevant legislation: responsible pharmacist notice displayed; responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs registers, with running balances maintained and regularly audited; records of patient returned controlled drugs. The PMR was backed up. And alterations to records were attributable, by notes and signatures e.g. in CD registers.

Staff members were aware of the need for confidentiality. They had undertaken training and there was a policy in place. No person identifiable information was visible to the public. Confidential waste was segregated for secure destruction.

All staff members had undertaken training on safeguarding and there was high awareness of various aspects of this. The pharmacist knew the process to be followed to raise a concern and there was a chaperone policy in place. The pharmacist was PVG registered.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. Pharmacy team members have access to training material and protected time to ensure that they have the skills they need. Pharmacy team members can share information and raise concerns to keep the pharmacy safe. They discuss incidents, and learn from them to avoid the same thing happening again.

Inspector's evidence

Staff numbers working in the pharmacy: two job-share pharmacists, one full-time manager who was also a dispenser, one full-time accuracy checking technician (ACT), four part-time dispensers, one part-time medicines counter assistant who was dispensary trained, and dispensed on Saturdays, two part-time medicines counter/dispensary assistants, one worked Saturday only and one delivery driver. Typically, there were two dispensers, one medicines counter assistant, the ACT and a pharmacist working. At the time of inspection there was one dispenser short due to annual leave. Certificates of qualification were displayed. Staff members were observed to manage the workload and the skill mix was suitable.

Protected time was provided for accredited courses, and paperwork was sent for signoff in a timely manner. Monthly training modules were undertaken, usually the day they were received. Protected time was provided for all staff members to undertake this. The manager explained there was a new process being implemented for staff development, and she was in the process of generating paperwork for all staff members. Meetings were planned over the following months.

The various individuals were observed going about their tasks in a systematic and professional manner. They were observed to ask appropriate questions when selling medicines over-the-counter. Examples were described of frequent purchase attempts, and there was clear awareness of items likely to be abused.

Openness, honesty and learning were demonstrated by their approach to near miss and error recording, and discussion within the team. Individuals described being comfortable when owning up to their own mistakes. Information from head office was shared e.g. the 'daily dose' publication. Meetings were held to discuss anything topical, and recently the reclassification of gabapentin and pregabalin to schedule 3 controlled drugs had been discussed. Monthly safer care meetings were held following near miss and error reviews, and case studies were discussed if these had been received from head office.

Team members were aware of a confidential helpline to raise concerns and they knew how to contact the superintendent or area manager. Appropriate responses were given to scenarios posed. They were also aware of who to contact locally if there were any concerns or issues regarding controlled drug management.

Targets were set for various parameters. Several were related to processes, stock and retail topics. And these were met. This had recently resulted in rewards for all team members. This had been motivating, and encouraged more good practice, including professional processes. Team members explained that they only offered services to patients they believed would benefit from them.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for the services it provides. The pharmacy team members use a private room for some conversations with people. People cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

This was a reasonably sized pharmacy premises which was observed to be very clean and tidy. Over the past 2 years or so, a lot of work had been undertaken to improve stock control and remove clutter. A cleaning rota was followed and the floor was swept every night.

Observation was made of a member of staff cleaning the medicines counter.

Premises were observed to be well maintained. 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. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. There was a consultation room with a desk, chairs, sink and computer which was clean and tidy and the door closed providing privacy.

Equipment was stored in locked cupboards. Sundries such as gloves, antibacterial wipes and sharps boxes were available and stored in cupboards.

Temperature and lighting were comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy team provides safe services. Pharmacy 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.

Inspector's evidence

There was good physical access by means of a flat entrance and an automatic door. The pharmacy displayed a list of the services it provided. A hearing loop in working order was available. Part of the medicines counter was low, providing access for wheelchair users. Strategies were used with dispensed medicines to ensure patients with visual impairment could identify them e.g. using bottles for some items, and different numbers of paperclips attached to skillets to identify other items. Signposting to other services was described e.g. needle exchange, and travel services. Leaflets on a range of topics were available.

All staff members wore badges showing their name and role. Dispensing work flow was observed to be logical, with designated areas for different types of dispensing. The pharmacy used coloured baskets, labels to identify high-risk medicines or those requiring special storage, and a system so relevant information was shared with the pharmacist. 'Walk-in' prescriptions were prioritised, then standard collection service, and finally managed repeat prescriptions. This ensured that dispensed medicines were ready for patients as they expected. Prescriptions with many items on them were dispensed before single items, to minimise pressure and therefore risk if patients presented at the pharmacy before these were ready. Dispensing audit trails were in place in terms of initials on dispensing labels of personnel who had dispensed and checked medicines. Owings were usually assembled the following day, and there was a documented owing system.

There was a delivery service and signatures were obtained on receipt. Preparation of items for delivery was observed, and this was well managed. There were designated labelled shelves for multi-compartmental compliance packs and other items due for delivery. The delivery driver had received training, and knew which items to take for delivery each day. There was an audit trail in place for this. The pharmacy manager believed there was a fridge on the van for items that required cold storage.

Multi-compartmental medicine devices (compliance packs) were managed on a four-weekly cycle with four assembled at a time. Patient information leaflets (PILs) were supplied with the first instalment of each prescription. Basic tablet descriptions were included on backing sheets e.g. round white tablets. This may not be enough information for identification if there were several similar tablets. Robust records were kept for each patient including a dose regime template. Prescriptions were ordered well in advance to ensure any queries could be addressed, and medicines assembled prior to the expected date of supply. There was an audit trail of phone calls and queries including the name of the GP, name of person who took the call in the pharmacy, name and date of action being taken, and the date new or replacement prescriptions were received. People collecting compliance packs signed to confirm this. This was following an incident when a person presented at the pharmacy on two consecutive days, having forgotten that she had already collected a medicine.

Methadone instalments were poured by a dispenser, and checked by a pharmacist using a

MethaMeasure pump device which had been recently installed. People were identified by their photograph held on the system, and were asked for their name, address, expected dose, and sometimes date of birth. The fingerprint function of this device was not used due to its location. Sugar free methadone instalments, and instalments for tablets for this patient group were assembled weekly, usually on a Saturday by a dispenser or accuracy checking technician (ACT), and checked by a pharmacist. These were then stored in a controlled drug CD cabinet. Observation was made during the inspection of a dispenser highlighting a concern to the pharmacist that a person did not seem particularly well, when presenting for supervised methadone. The pharmacist had a conversation with the person in question and made the judgement that he was well enough for this medication. Other instalment prescriptions were assembled one instalment at a time. And following a supply the prescriptions were placed immediately into the process to dispense the next instalment. These were stored in designated labelled drawers. And this process ensured there was only one instalment available, and medicines were always ready when people expected them.

Retrieval shelves for dispensed medicines waiting to be supplied were observed to be tidy with items stored in an orderly manner. These were cleared each week following the standard operating procedure, meaning that the shelves were quite empty, giving good visibility to staff members of all items. There was no evidence of uncollected items suggesting poor compliance with essential medicines.

Clinical checks were undertaken by a pharmacist, and people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin were given appropriate advice and counselling. Written information and record books were provided if required. The valproate pregnancy prevention programme was in place. A search had identified one patient who had been counselled by a GP and pharmacist. Recently a new patient had presented with a prescription for sodium valproate tablets. The pharmacist had counselled patient and provided information, which had already been done by the GP.

The non-steroidal anti-inflammatory drug (NSAID) care bundle had been implemented and written and verbal information was given to people supplied with these medicines supplied over-the-counter, and on prescriptions. 'Sick day rules' were also discussed with people on certain medicines, so that they could manage their medicines when they were unwell.

For NHS services, the pharmacy followed the service specifications. And patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, chloramphenicol ophthalmic products and chlamydia treatment. These were current and the pharmacist had been trained and signed them. Private PGDs were in place for flu vaccination during flu season.

Medicines were supplied to some patients on the chronic medication service (CMS) serial prescriptions. These were dispensed around two weeks before the expected date of supply to ensure they were always ready as patients expected. As retrieval shelves were cleared on a four-weekly cycle, these could potentially remain on shelves two weeks past the expected date of collection. This was seldom observed, but on occasions when it was, patients were contacted. Usually they had adequate supplies at home and had not been without medication. No pharmaceutical care issues were identified when registering patients for the chronic medication service.

Pharmacy team members were empowered to deliver the minor ailments service (eMAS) within their competence. There was a template on the medicines counter for people to complete when requesting medicines on the service. Individual pharmacy team members were aware of situations that needed to be referred to the pharmacist and gave appropriate responses to scenarios posed. The pharmacist could overhear most conversations, and was able to intervene if necessary.

The smoking cessation service was delivered by a pharmacist or accuracy checking technician (ACT). There were currently around 14 patients, all receiving nicotine replacement therapy.

All pharmacy team members were trained to measure blood pressure, following a standard operating procedure and referring to the pharmacist appropriately. Diabetes testing was undertaken by the pharmacist, ACT or one trained dispenser. The meter was calibrated regularly, and the standard operating procedure was followed. Neither of these services were requested frequently.

Invoices were observed from licensed suppliers such as AAH.

The pharmacy did not comply with the requirements of the Falsified Medicines Directive (FMD). Equipment was installed, but not in use. There had been no training or standard operating procedures (SOPs) implemented.

Records of date checking and stock rotation were observed, and items inspected were found to be in date. Medicines were stored in original packaging on shelves/in drawers. The top 150 items were in white baskets above the shelves. Stock was rotated on shelves filled on Saturdays. Staff members explained that this works well and they never ran out of these commonly supplied items. Items requiring cold storage were stored in a large fridge with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. There was a fact sheet about insulin devices on the fridge door.

Controlled drugs (CDs) were stored in CD cabinets. Space was well used to segregate stock, dispensed items and obsolete items. Sugar free methadone instalments were poured weekly as noted above, and each day that day's instalments were moved to a CD cabinet containing other controlled drugs. This ensured that the current day's instalments were separate from other days, to minimise the risk of an extra supply being made. This also showed visibly any uncollected instalments at the end of the day.

Sale of P medicines was as per the sale of medicines protocol. Medicines were stored in Perspex boxes, labelled that they were not for self-selection. Occasionally people did help themselves, but the boxes were close to the medicines counter and a staff member would usually see this. There were prompts on the tills for all P medicines, so at the point of sale, the staff member would be alerted. A list of items to be referred to the pharmacist was displayed close to the medicines counter for reference. Cards with information to be supplied to people purchasing non-steroidal anti-inflammatory drugs (NSAIDs) were available at the medicines counter. There were also aide memoir cards provided by NHS education for Scotland (NES) with advice to be supplied to people purchasing several different medicines e.g. aspirin, paracetamol, ibuprofen and codeine.

MHRA recalls and alerts were actioned on receipt and records kept. Patients were contacted following patient level recalls. Items received damaged or faulty were returned 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

Texts available in the pharmacy included current editions of the British National Formulary (BNF) and BNF for Children.

There was internet access allowing online resources to be used.

Equipment required to deliver pharmacy services was kept in the consultation room where it was used with patients accessing these services. This included a carbon monoxide monitor maintained by the health board, a blood pressure meter which was replaced or calibrated as per the manufacturer's guidance, and blood testing equipment calibrated as per guidance. Records of this were observed.

ISO and Crown stamped marked measures were kept by the sink in the dispensary, and separate marked ones were used for methadone.

There was a MethaMeasure pump available for methadone use and this was cleaned and test volumes poured daily. Clean tablet and capsule counters were also kept in the dispensary, and a separate marked one was used for cytotoxic tablets.

Paper records were stored in the back-shop area. Archived records were well filed in labelled boxes. Computers were never left unattended and were password protected. Screens were not visible to the public. Care was taken to ensure phone conversations could not be overheard.

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.