General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 1 Crossgate, Cupar, Fife, KY15 5HA

Pharmacy reference: 9011074

Type of pharmacy: Community

Date of inspection: 07/01/2020

Pharmacy context

This is a community pharmacy situated on the high street of a town, close to other pharmacies. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it supplies medicines to care homes. 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 services including smoking cessation, blood pressure measurement and diabetes testing. The pharmacy relocated around nine months previously from smaller premises close by.

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	1.2	Good practice	Team members are all involved in regular reviews of errors and incidents. They learn from them and make changes to avoid the same mistakes happening again.
2. Staff	Standards met	2.2	Good practice	The pharmacy provides time and material for team members to complete training to ensure they have the knowledge and skills they need. Team members make this a priority even at busy times.
		2.3	Good practice	Team members put great effort into sourcing and supplying medicines for people. And they explain any difficulties clearly to people and prescribers.
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 and incidents to learn from them. They review these, discuss them and make changes to avoid the same mistake happening again. The also discuss things that have happened in other pharmacies and make changes to avoid them happening in this pharmacy. Team members discuss feedback from other people and used this to improve pharmacy services. The pharmacy keeps all the records that it needs to. And it keeps people's information safe. Pharmacy 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. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs and individual competence records confirmed which SOPs each team member was competent in. The pharmacy had a folder on the dispensary wall containing new SOPs to be read. A recent one was about prescription stock selection. This was giving increased flexibility to either select stock, or label prescriptions first, depending on the situation. 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. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It displayed a 'One-call-menu' on the dispensary wall clarifying how to report incidents. It also had a list of contact details for other healthcare professionals and stakeholders e.g. health visitors, GPs, controlled drugs accountable officer, and suppliers. The team used a list of daily and weekly tasks, which they signed as they were completed, to ensure all essential tasks were undertaken. The tasks included pouring methadone, controlled drugs running balance audits, date checking, and completing safer care audits.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month and discussed these. The pharmacy had been very busy a few weeks previously and team members were reminded not to rush and ensure they double checked their dispensing before passing it for the final accuracy check. An inexperienced team member had been trained in inhaler devices following an incident that highlighted a lack of knowledge. Sometimes team members had not recorded contributing factors and learnings from incidents when they were busy, so they were reminded of the importance of this to avoid similar incidents. The team agreed and implemented an action plan each month. Examples observed included reminders to record all near misses, keep benches tidy, put baskets away, always use the correct colour of basket and always use a separate basket for each patient. The pharmacy had made two errors reaching people, both at the time of supply. These had resulted in all team members being reminded to double check addresses when handing medicines out, which was observed. And locum/relief pharmacists were encouraged to keep the checking bench clear, only checking one person's medicines at a time to avoid the wrong bag label being attached. The pharmacy undertook safer care audits each week considering people, processes and the environment. When there had been a full-time pharmacist, she had undertaken this task, but all team members were

currently involved. The pharmacy superintendent also provided safer care information, and this was on a board along with the pharmacy's action plan. The pharmacy had actioned suggestions related to similar looking medicines e.g. moving amlodipine.

The pharmacy had a complaints procedure and welcomed feedback. Team members had been told by people that the GP practice sent texts saying prescriptions would be ready at a certain time. But people did not realise that referred to prescriptions available in the surgery rather than medicines ready in the pharmacy. The team was considering options to address and manage this.

The pharmacy had an indemnity insurance certificate, expiring 30 June 20. The pharmacy 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 did not always record prescriber details in the methadone register, which was a legal requirement. They sometimes recorded 'CAS' (community addiction services) which was not compliant. This did not present any risk to people. They usually signed 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 undertaken training on the general data protection regulations (GDPR). The pharmacy had a GDPR statement on the wall where people could see it. Team members 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 locally and had access to contact details and processes. The pharmacy had this information on the dispensary wall. It had a chaperone policy in place and displayed a notice telling people. The relief pharmacist working at the time of inspection was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide services. Team members use their judgement and experience to manage workload. They have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training. Team members make decisions and use their professional judgement to help people. They give explanations to people and their doctors when there are difficulties obtaining medicines. And they do their best to find medicines or suggest alternatives. Members share information and can raise concerns to keep the pharmacy safe. They make suggestions to improve services. And they discuss incidents to learn from them and avoid the same thing happening again.

Inspector's evidence

The pharmacy had not had a permanent pharmacist for the past five months. Relief and locum pharmacists provided full-time equivalent pharmacy cover. The pharmacy had the following staff: one part-time pharmacy technician, two dispensers working four days per week (one was currently working five days), one full-time supervisor/dispenser, one part-time medicines counter assistant working three hours each afternoon, two trainee Saturday assistants undertaking the joint dispensary/medicines counter course, and two part-time delivery drivers. The supervisor was responsible for the medicines counter and retail area. And she assisted in the dispensary when she was able to. She worked on the medicines counter in mornings. This was observed to be challenging as she tried to undertake management tasks as well. One Saturday assistant was very new so had only undertaken induction training so far. At the time of inspection, a relief pharmacist and four team members were working, which was typical. They were interrupted frequently by the phone, which they described as usual. The medicines counter was also busy for the duration of the inspection. Team members described increased footfall since the pharmacy had relocated a few months previously. The pharmacy had around six new patients each day which was leading to increasing dispensing volume. Team members were observed to be methodical and organised. They were therefore able to manage the workload. But they described feeling stressed and under pressure at times. Part-time team members had some scope to work flexibly providing contingency for absence.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. They completed regular on-line modules and annual mandatory training such as information governance and pharmacovigilance. The pharmacy provided Saturday team members undertaking accredited courses with additional time to complete coursework. The various individuals 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. Several examples of quality conversations face-to-face and on phone calls were observed. Team members demonstrated good knowledge of medicine supply problems. And they could effectively explain the issues to patients and prescribers. They had good relationships with GP practice personnel. And this was observed. A dispenser explained a supply problem to a patient. Then she contacted other pharmacies to locate the item. When this was unsuccessful, she used appropriate resources and the pharmacist’s expertise to identify potential alternatives. She checked stock levels in the pharmacy then contacted the GP practice to share this information. This enabled the prescriber to consider an alternative therapy. This was observed to be

very time consuming, affecting dispensing work-flow. But it would provide a good outcome for the patient. The team explained that this was normal practice and was now expected by prescribers locally. (The end result was not known during the inspection.) Another example was observed of a request for an emergency or urgent supply. The team member took thorough details and explained the process effectively to the patient. Other examples of sharing information between team members were observed. And they documented relevant details on patient medication records (PMR). This included information such as only supplying prescription medication to the person it was prescribed for, not a representative.

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. A team member described suggesting a slight change to how instalment prescriptions were dispensed. The team discussed then adopted this. The 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. Team members had regular monthly team meetings. They kept notes of these. Topics they had recently discussed included changes in supplying chloramphenicol eye products to young children, computer processes, prescription endorsing and record keeping. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. But team members explained that these were only used as reminders to offer people services that they would benefit from.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean, and suitable for the pharmacy's services. The pharmacy team members use a private room for some conversations with people. Other people cannot overhear these conversations. The pharmacy is secure when closed. Team members raise concerns when there is any fault or damage to the premises. And the pharmacy addresses these appropriately.

Inspector's evidence

These were reasonably sized premises incorporating a retail area, dispensary, storage space and staff facilities. The pharmacy team used a room in the basement to manage care home and multi-compartment compliance aid dispensing. The premises were clean, hygienic and well maintained. The front door was catching on a floor tile, but the team managed this by adjusting it to enable the bolt to line up to lock the door. Team members had reported this issue. The door had been inspected but no improvement was possible. 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. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them access and use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. 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. 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. Team members told the pharmacist when they identified changes or new medicines on people's prescriptions. Sometimes they used a written note to remind the pharmacist. They 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. The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time, at least one week before the first pack was required. Team members kept thorough records and documented these as per the company SOP. They stored the records logically in folders depending on the week the prescription was managed. Team members included tablet descriptions on backing sheets and attached these firmly with glue to the compliance packs. They supplied patient information leaflets with the first pack of each prescription. The pharmacy had a list people it supplied with compliance packs on the wall, including relevant detail and the day of supply. The pharmacy also provided pharmaceutical services to two care homes. Team members maintained thorough records for each resident, and they were also listed on the wall with their room number and date of birth for reference. The pharmacy was in the process of changing one home from a racked system to original packs for their medicines. Team members were undertaking this in a methodical manner and liaising with care home staff. They already supplied the other home with original packs. The pharmacy managed each home in a separate week to avoid any possible confusion. These were consecutive weeks, leaving the following two weeks to manage paperwork and focus on multicompartment compliance packs. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these in entirety on receipt of prescriptions. The pharmacy had previously done this weekly but following a staff suggestion this was changed and was working well. It stored dispensed instalments in named baskets on shelves above other dispensed medicines.

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 team kept these filed on the dispensary bench for ease. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had the information on the dispensary wall. It had undertaken a

search for people in the ‘at-risk’ group and the pharmacist had counselled them appropriately. It also had the isotretinoin pharmacist guidance checklist on the dispensary wall. But the team was not aware of the non-steroidal anti-inflammatory drug (NSAID) care bundle or ‘sick day rules’. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, and emergency hormonal contraception. It also followed private PGDs for flu vaccination occasionally if there was a pharmacist available trained in vaccination. The pharmacy empowered team members to deliver the minor ailments 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 pharmacy offered blood pressure measurement and diabetes testing, but these were not often requested. All team members were trained and competent to measure blood pressure, and a few were able to test for diabetes. They followed SOPs and referred results to the pharmacist. One dispenser delivered the smoking cessation service. She described this as time consuming, with the counselling being important. People using the service had given positive feedback about the effectiveness of the time spent.

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). It had the equipment on the premises and team members had completed a training module, but the system was not active. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It 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. 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 pharmacy had the NHS Education for Scotland (NES) over-the-counter (otc) consultation principles on the wall as an aide memoir.

The pharmacy actioned MHRA recalls and 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. And it kept a folder of commonly used patient information leaflets to supply to people whose medicines were not supplied in original packs.

The pharmacy kept equipment required to deliver pharmacy services in locked cupboards 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 – it had a label with date of replacement July 2020; and diabetes blood testing equipment calibrated as per guidance. Records of this were observed. The pharmacy also had sundries required for vaccination including emergency adrenaline. It was two months out of date and team members were aware of this. The pharmacy was not currently offering flu vaccination. It was keeping the adrenaline in case it was required in emergency as there had been recent supply difficulties. 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 team kept clean tablet and capsule counters in the dispensary.

The pharmacy stored paper records in the consultation dispensary and back shop areas 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.